ADMINISTRATION'S FISCAL YEAR 1983 BUDGET PROPOSAL

HEARINGS
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
NINETY-SEVENTH CONGRESS
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THE ADMINISTRATION'S FISCAL YEAR 1983 BUDGET PROPOSALS

FRIDAY, MARCH 12, 1982

U.S. SENATE,
FINANCE COMMITTEE,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 2221, Dirksen Senate Office Building, Hon. Robert Dole (chairman) presiding.

Present: Senators Dole, Durenberger, Chafee, Grassley, Long, and Byrd.

The CHAIRMAN. Well, we will continue our hearings this morning. There will be other members that come and go. I don't want to delay the witnesses.

Our first witness this morning will be Dr. Daniel T. Cloud, president of the AMA, accompanied by Fred C. Rainey. And I think someone else. Or I know someone else, but I don't know who it is. But you can identify those who are accompanying you, Dr. Cloud. And your entire statement will be made a part of the record. As I understand, you intend to summarize it. And we hope to have some time for questions.

STATEMENT OF DANIEL T. CLOUD, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

Dr. CLOUD. Thank you. Good morning, Mr. Chairman and members of the subcommittee. My name is Daniel T. Cloud, M.D. I am a pediatric surgeon in private practice in Phoenix, Ariz. And I am president of the American Medical Association. Accompanying me today is Fred C. Rainey, M.D., seated on my right, a physician in family practice in Elizabethtown, Ky. Dr. Rainey is chairman of the AMA's Council on Legislation. And also accompanying us is Mr. Ross N. Rubin, seated on my left, who is the Director of the AMA's Department of Federal Legislation.

The American Medical Association is indeed pleased to have the opportunity to appear before your committee today.

Mr. Chairman, in recent years the expansion of entitlement programs by the Federal Government has led to the situation where Congress has little control over the major portions of the Federal budget. Now that major program changes are in place concerning discretionary programs, Congress should turn its attention to reform of entitlement programs.

We have been asked to appear today to comment on changes in the medicare program as proposed by the administration designed to generate approximately $5.5 billion in Federal budget savings. Respectfully, we do not intend to address those cuts today, Mr. Chairman, because we believe that addressing individual items in particular programs does not provide the direction and leadership necessary to chart a course for the delivery of health care in this country for this and future decades. Rather, Mr. Chairman, we believe it is now time to step back from the pattern of looking at individual program budgets and attempt to place in perspective the role of the Federal Government in financing and delivering medical services in the future. Now is the time to set priorities for the future and not continue to deal with crises on an annual basis.

We believe it is essential to construct a fundamental, coherent, long-range national policy on health care. A policy that realistically addresses the quality, accessibility, and cost of health care, and the role of government at all levels in this effort.

The American Medical Association will take the initiative in this endeavor. There is a need for an evaluation of long-term health policies that will lead to proper care for our citizens within the available national resources. We have begun such an evaluation, and will make recommendations concerning health care, both long and short term. In our view, Mr. Chairman, there should be no sacred programs. A primary goal should be to meet the needs through government resources for those not able to provide for themselves.

Today, we will not address certain program provisions that specifically address provider or physician reimbursement. We believe the time has passed for comments that emphasize only that approach. We ask all interested health groups, whether they appear here today or not, to join us in evaluating the overall situation with a long-term perspective. The answers to our health problems are not to be found in arbitrary caps, in inequitable benefit reductions, in arbitrary cost shifting or in quick fix expediency. Solutions will be found only when all interested parties participate in a basic restructuring of Federal programs. The American Medical Association is committed to a leadership role in setting a new course. We recognize that in an era of finite resources we must all work to establish a course that will continue to provide the finest health care system in the world.

Mr. Chairman, I want to emphasize that this statement is a clear signal that the American Medical Association intends to step away from the status quo and embark upon a comprehensive assessment of Federal programs for health care that will assure that quality and accessibility of care for patients will be preserved within the available national resources.

Thank you.

The CHAIRMAN. Thank you, Dr. Cloud.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance
United States Senate

Presented by

Daniel T. Cloud, M.D.
Fred C. Rainey, M.D.

RE: Proposed Budget Cuts Affecting the Medicare and Medicaid Programs and the Maternal & Child Health Block Grant

March 12, 1982

Mr. Chairman and Members of the Committee:

My name is Daniel T. Cloud, M.D. I am a pediatric surgeon in practice in Phoenix, Arizona, and President of the American Medical Association. With me is Fred C. Rainey, M.D., a physician in family practice in Elizabethtown, Kentucky, who is Chairman of AMA's Council on Legislation. Accompanying us is Ross N. Rubin, Director of AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to appear before the Committee today.

Mr. Chairman, this nation is facing many problems. Unemployment is increasing. Interest rates are still at crippling levels, and the projected $100 billion federal budget deficit will likely continue to place upward pressure on those interest rates.

The American Medical Association is committed to an economy characterized by strong, real growth. This is absolutely necessary to ensure a quality living standard for all our citizens.

Last year when the President called for significant cuts in non-entitlement programs, Congress responded and at the same time began the transfer of federal categorical grant programs to the states. We are now beginning to see the first results of this action. There are significant reductions in the increases in the cost of living and some recent moderation in interest rates.

However, in recent years the expansion of entitlement programs by the federal government has led to the situation where Congress has little control over the major portions of the federal budget. Now that other program changes are in place, Congress should turn its attention to reform of entitlement programs.

The Administration has proposed numerous changes in the Medicare and Medicaid programs designed to generate approximately $5.5 billion in federal budget savings. Respectfully, we do not intend to address those cuts today, Mr. Chairman, because we believe that addressing individual items in particular programs does not provide the direction and leadership necessary to chart a course for the delivery of health care in this country for this and future decades.

Rather, Mr. Chairman, we believe it is now time to step back from the pattern of looking at individual program budgets and attempt to place in perspective the role of the federal government in financing and delivering medical services in the future. Now is the time to set priorities for the future and not continue to deal with crises on an annual basis. We need a fundamental, coherent long-range policy that realistically addresses the quality, accessibility, and cost of health care and the role of government at all levels in these efforts.

The American Medical Association will take the initiative in this area. There is a need for an evaluation of long-term health policies that will provide proper care for our citizens within the available national resources. We have begun such an evaluation and will make recommendations concerning health care, both long- and short-term.

In our view, Mr. Chairman, there should be no sacred programs. A primary goal should be to meet the needs through governmental resources for those not able to provide for themselves.

Mr. Chairman, health care is too important to reside within a Cabinet Department that has a major share of its activity devoted to welfare. Health care matters should belong within a distinct Department of Health, both at the federal and state levels.

Today we have not spoken about certain program provisions that specifically address provider or physician reimbursement. We believe the time is past for comments that emphasize only that approach. We ask all interested health groups, whether they appear here today or not, to put aside individual self interest and join us in evaluating the overall situation with a long-term perspective.

Mr. Chairman, the answers to our health problems are not to be found in arbitrary caps, in inequitable benefit reductions, in arbitrary cost shifting or in quick-fix expediency. Solutions will be found only when all interested parties participate in a basic restructuring of federal programs in an era of finite resources.

The American Medical Association is committed to a leadership role in setting a new course. We recognize that in an era of finite resources we must all work to establish a course that will continue to provide the finest health care system in the world.

Let me make it clear that this statement is a signal from the American Medical Association that we will step away from the status quo and embark upon a comprehensive assessment of federal programs for health care that will assure necessary quality and access of care for all those who need such care.

The CHAIRMAN. It looks like a clear signal to me that you don't want to do anything, to be very frank about it. If we are going to do something short term—we've got short-term budget problems. We cannot wait 2 or 3 years for some long-term change. And I'm disappointed that you are not willing to help us come to grips with the budget right now. We've got interest rates that are driving people out of business; we've got large deficits, and the time the AMA gets around to helping us, the cost of medicare may be $100 billion. So I am not very excited about your testimony.

Dr. CLOUD. Well, Mr. Chairman, I understand what you are saying. And I do understand your concerns. And I do understand the problems that beset you. However, we have, in years gone by, testified many times on these same issues. We now believe and it was just determined about 3 weeks ago in an action by our board of trustees that a long-range review of Federal health programs is the best course of action for us to take that can provide the best opportunity for helping you in the long run.

The CHAIRMAN. And I understand that. Certainly Senator Durenberger is the leading light in that area. He is here this morning.

We are being asked—I am in my chairmanship of the Nutrition Subcommittee to cut food stamps, to take money away from poor people. And that program costs $10 or $11 billion, and here's a program that is up $56 billion, headed for $110 billion. And I don't get anything from the AMA as far as savings are concerned. Not $1 are you willing to say that we can save in the fiscal year 1983.

Mr. RAINEY. Mr. Chairman, if I might respond. I think that you have just touched upon the concern that has prompted the American Medical Association to assume the current position that we now have. You and I and others have watched this program over the years, and it seems that while there are laudable benefits of the program that there have been constant problems with it. Now it would appear that the greatest problem is that of cost. It is the position of our board of trustees that, while some of the proposals have merit, we will never be able to accomplish the goal that it appears necessary to accomplish if we are to bring the cost under control by dealing on an item-by-item basis. The only way that cost can be effectively brought under control may be to back off and develop an entirely new program. One that would not deny access to care. One that will not injure the quality of care. One that we can afford. It appears to us that while you may be able to reduce costs in some specific areas, that the cost even after that has been done will still be a major problem. And it's our feeling that perhaps a better program should be developed, hopefully, with the help of other health professionals and Congress and the administration.

I recognize the fact that the clock goes on. And I would hope, however, that it would not take several years to accomplish what we have in mind. Certainly, it will take a considerable amount of time, but several years has not entered my mind at least as the timeframe necessary to develop the program that we are talking about. I readily admit it is going to be a very complex, monumental effort, but it is our feeling that the time has come when that effort should be made.

The CHAIRMAN. Well, one suggestion has been that we pay single price for a given service. Do you support that?

Dr. CLOUD. Pardon me, Mr. Chairman.

The CHAIRMAN. About a single price. Let's say, $500 for an operation whether you get it in Los Angeles or New York. Right now, they are all over the lot. They vary from $500 to $2,000 for the same operation but because of different locations. Do you have any objection to having a single price for a given service?

Mr. RAINEY. As a private practitioner, I have problems with that. I think that if I, as a private practitioner, wish to charge less, I should be able to charge less.

The CHAIRMAN. We would let you do that. We just wouldn't let you charge more.

Mr. RAINEY. I was going to extend that a little bit. If there were reasons that I feel are justified, I would charge more. I would like to have that opportunity. I believe that a single national price system is not consistent with the free enterprise system.

The CHAIRMAN. You know, we are about to bankrupt the system. That's our problem.

Mr. RAINEY. I agree with you that there is a major cost problem. But I don't believe that problem can be directed to physicians. In the last 5 years, the increase in physician fees has been below the all-services index. There are many areas of cost over which physicians have absolutely no control. Unfortunately, the spiraling inflation affects health care just as it does the cost of clothing, food, automobiles, housing, and everything else. The cost of labor is a factor over which we have no control.

The CHAIRMAN. I agree with that. We had a chart the other day that underscored what you said. The hospital costs have gone up about 19 percent. We are talking about hospitals. But they don't put people in hospitals, the doctors do so you get a little credit for that.

Dr. CLOUD. Mr. Chairman, that's all very true. And the concerns we have when you talk about a matter such as a fixed price for an operation across the country, those concerns lead to many other corollary concerns. That's why we think that a simplistic approach to addressing these issues is simply not going to work. We think we should address the total package. And that's what we are here to say today.

The CHAIRMAN. I hope that we will have some assistance because I don't think we can just say we cannot do anything now, we have got to wait for some long-term solution. We know this is a disaster, but don't ask us to try to even stem the tide, which is about to engulf us. I'm convinced that if we cannot save some money in medicare, $56 billion, then we might as well just not have any hearings. Just close up shop and say everybody wants interest rates lower, but nobody wants to make a contribution. And we are going to have to find some ways, hopefully, that we can find 11 votes for on this committee. If not the administration's approach—I don't suggest that's the only approach—but we need some assistance in finding some ways to save a few billion dollars. And not wait—maybe it's not years. Maybe it's only 2 or 3 years. But we cannot wait 2 or years. If we don't do something about deficits and interest rates, I'm not certain what might be happening in 6 months.

Dr. CLOUD. Mr. Chairman, if I might comment on that. We surely don't want to leave the impression with you, sir, or your committee, that we are suggesting that we do nothing. We are, indeed, embarking upon a program to try and provide for you the assistance that you need. And as soon as we can provide it, we will.

The CHAIRMAN. We are talking about May.

Dr. CLOUD. Well, Mr. Chairman, I don't know if I can promise you anything by May, but I will promise you that we will do it as quickly as we can and consistent with what we think is the right thing for the country.

The CHAIRMAN. Well, the right thing for the country is to bring down spending. We are being pushed by our majority leader on a daily basis to come—we've had daily meetings on how we can reduce spending and raise revenues and get a package together which we can add to the debt ceiling as it goes through this committee or on the Senate floor. And we can't postpone that because if we don't reach the debt ceiling, we cannot pay our bills. So time is of the essence. So if you could be helpful in that area, it would be appreciated.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I have found the last several minutes very interesting. I apologize for not being here for your prepared statement. Dr. Cloud is getting, in effect, a dose of the medicine that he, on several occasions asked me to give his membership. Back in Minneapolis, when I came to talk about competition and other phases of health policy, he said, "That's fine, Senator. But first, give us a real dose of realism about what is going on in Washington."

Mr. Chairman, I know that you have been committed to working toward changes in health policy longer than a lot of others including Dave Durenberger. Nobody questions Bob Dole's commitment to changing the way we meet the health needs of the people in this country.

The CHAIRMAN. Well, I don't want to leave the impression that somehow Dr. Cloud is responsible for all of our problems. [Laughter.]

Senator DURENBERGER. We all know that.

The CHAIRMAN. We will each take a chunk of that.

Senator **Durenberger**. And I also want you to know that although Dr. Cloud is a very realistic president, his association needs a good dose of realism. We have serious short-term problems that need long-term solutions. Genuine changes in the way we buy and deliver health care will take 8 to 10 years.

My concern for the short term is that we deal with what really happens when we make a budget reduction. I'd like to know, for example, the extent to which physicians shift their costs to private paying patients as a result of Medicare and Medicaid cuts.

Mr. **Rainey**. I can respond to that as a practicing family practitioner in a rural area. And I can tell you that it is a real problem. It just so happens that my overhead stays about the same regardless of what the Federal programs do. And as you well know—I need not tell any of you—in the recent past, the overhead of everyone has gone up, up, and up. As the Federal programs are cut back on their reimbursements, I have to generate that overhead from somewhere. And the only place to turn is private pay patients. And you hit the nail on the head. It is merely cost shifting.

Senator **Durenberger**. To what extent do you just not see or try not to see medicaid or medicare eligible patients?

Mr. **Rainey**. Try not to see them? No, I don't do that. I think that would be wrong. I think we are placing the problem on the back of the wrong individual if you place it on the back of the patient. No one wishes to become ill. And if they happen to become ill, and they happen to be a medicaid recipient, that individual is entitled to the same care as a private pay patient. And the same is true of a medicare recipient. I just could not accept that approach.

Senator **Durenberger**. Thank you.

The **Chairman**. Senator Chafee.

Senator **Chafee**. Thank you, Mr. Chairman. I apologize for being late and am just reading Dr. Cloud's statement here. One of the pieces of evidence cited the other day in the testimony of Secretary Schweiker was that the cost of the services for which the Government pays—I think he restricted it to lab services, but somebody correct me if I am wrong—is sometimes as much as five times the rate that a private patient pays should he contract for these services individually. Is my recollection right on that, Mr. Chairman? Was it the lab fees?

Senator **Durenberger**. There was an article in the Washington Post reporting a local study about some form of lab fees.

Senator **Chafee**. In any case, I think the Secretary testified to lab fees. How can that be? Now I know you are not representing the lab technicians or anything like that, but does that testimony seem possible? I am not disputing the testimony because we've had shocking evidence around here of overcharges and differences in charges made to the Government through the medicare programs vis-a-vis what a private patient pays. Now tell me the travail of a situation like that. A medicare patient comes to you. You do some tests. The tests go to the lab. The bill comes back. Could the total be five times what you pay for a similar service for a private patient?

Dr. **Cloud**. Sir, I am not familiar with the testimony that you heard the other day. And I don't have any data of my own to support or to negate what you were given. I think it is possible that in some instances there may be some abuses, but I can't respond beyond that. I don't really understand how that would happen in an ordinary way. I think it would be unlikely. There may be some areas where this sort of thing has happened. But I am really not familiar with the testimony. And I'm sorry I can't respond.

Senator CHAFEE. I'm giving you the testimony. The testimony was that the Federal Government is overcharged or charged five times the rate that a private patient would pay for lab services. He didn't indicate that this was a remote or unusual instance.

Dr. Rainey, do you have anything you can contribute on that?

Dr. RAINEY. Based on just that information alone, I would say there is a problem somewhere and it doesn't sound reasonable. But I would like to know more about the situation. And, in fact, I think that we would welcome the opportunity to look into the situation if we could have the specifics of that case.

Senator CHAFEE. All right. Now let me ask you something else. It seems to me common practice—and I want your response to this—for a physician to charge more if the patient is covered by Blue Cross. This will certainly go to the maximum rate that is allowable under the Blue Cross schedule or any third party payers' schedule. These fees are frequently in excess of what a private patient would have to pay if the private patient came to see you. Can you comment on that?

Dr. RAINEY. I have difficulty accepting that as a general situation. I'm sure that may occur in isolated cases. But if we are talking about a majority of cases, and a common practice I just cannot accept that because I don't know of any of my colleagues—and I don't profess to know what everyone in this country is doing—but in the first place it would be very difficult from a bookkeeping standpoint. It would not be fair. It would not be right. I just cannot accept the fact that a significant percentage of the profession makes a difference in their charges.

Senator CHAFEE. Why wouldn't it be right? What's wrong with burying your charges? You are going to charge everybody the same thing?

Dr. RAINEY. Well, I thought the implication was that you would automatically charge more if the patient had some type of coverage whether it be a Federal program or Blue Cross or Blue Shield coverage. Was that it?

Senator CHAFEE. Under a third-party payer, there are schedules, are there not?

Dr. RAINEY. Correct.

Senator CHAFEE. The appendectomy is X dollars. A tonsillectomy is X dollars. So forth and so on. And there it is. That's what you can charge. My point is, and I have noted this and it has been related to me at home—I haven't had it personally followed up but I have no reason to believe otherwise, that if the patient comes in without the Blue Cross, without a third-party payer coverage that the physician, quite frequently, will charge less than what is permitted under the schedule. There is nothing immoral or illegal about it.

Dr. RAINEY. Let me rephrase my answer by giving you an example. Let's say that in my office I see a patient and it is in one office and all overhead is going to apply to all three types of patient. I see one patient with the same illness. It takes me the same length of time and effort and professional judgment to treat. That patient is a medicare recipient. I see another patient who happens to have Blue Shield or Blue Cross or any type of commercial coverage. And I see a third patient who is a medicaid patient. And I see a fourth who is paying out of their pocket. They don't have anything.

Senator CHAFEE. Right.

Dr. RAINEY. My charge is identical for all four. I think that is the generally accepted method of charging in our profession.

Senator CHAFEE. My time is up, I know, Mr. Chairman, but can Dr. Cloud just respond briefly?

The CHAIRMAN. Sure.

Dr. CLOUD. Thank you, Mr. Chairman. I think to supplement what Dr. Rainey has said is that I agree with what he gave you first as the response. But I would go further to say that in the event that it turns out that a particular patient is unable to meet that charge or perhaps to meet the payment that might be the balance between whatever his third-party coverage might be and what the normal fee might be, if there is then such a balance, it is then common practice to reduce that charge or to eliminate it entirely in order to accommodate the needs of the patient. That is to say, the amount that is collected or that is requested of the patient is reduced even though the basic charge might be the same going in.

Senator CHAFEE. In other words, you are saying that the patient would be assessed the same charge under Dr. Rainey's example, but a certain amount might possibly be excused.

Dr. CLOUD. Oh, yes, that's true.

Senator CHAFEE. I have other questions later, Dr. Dole.

The CHAIRMAN. I tried that but I didn't make it. [Laughter.]

Got into politics.

Senator Long.

Senator LONG. No questions.

The CHAIRMAN. Do you have another question? We have six more witnesses.

Senator CHAFEE. Yes. All right. I'm going to be brief. My problem with the whole medical delivery system in this country is that there doesn't seem to be any incentives anywhere to hold down the cost. Look at it from your point of view. What incentive is there for you to hold down the cost in any of your procedures when the patient, for instance, is covered by a third-party payer? Isn't the lid off? Why not play it safe? Send out all kinds of lab tests. Take every precaution. Somebody else is paying for it.

Dr. RAINEY. Well, if somebody else is paying for it in the case of the Government program, Senator, it is both you and I.

Senator CHAFEE. Yes. But you and I have such a tiny portion of the billions of dollars.

Dr. RAINEY. Well, there are certain times of the year that at least to me it doesn't feel tiny. But I don't believe that any of us, with hopefully very, very few exceptions, just totally ignore the cost of care. The problem is, Senator, that there are so many factors pushing up the cost of care that are beyond our control. Therein lies the problem. I just mentioned a few earlier. Inflation is one. Labor cost is another. New medical technology is third. And maybe one could make the argument we shouldn't have new medical technology. But I would suggest that if you or I or a member of our family happens to be the patient at that time when the new medical technology will save them, all of a sudden, that is very important to us. And I think patients have a right to access to any medical technology that is available at the given time.

I just don't believe that regardless of how much effort we, as private practitioners make, to hold down the cost of care that is going to solve the problem because there is such a large proportion of that cost that is absolutely beyond our control.

Senator CHAFEE. Beyond whose control?

Dr. RAINEY. The control of the physician.

Senator CHAFEE. Well, everybody comes in here and it's always beyond each person's control. The patient has no control. He's swept in the system. The physician can't control it.

The CHAIRMAN. Hospitals can't control it.

Senator CHAFEE. Hospitals can't control it. Somebody must be able to hold down these costs which are way out of line with the inflation in the United States.

Dr. CLOUD. Senator Chafee, if I could respond to that.

Senator CHAFEE. Yes.

Dr. CLOUD. I want to assure you that we are trying to find ways to hold down those costs. To add to what Dr. Rainey said, the American Medical Association has actively, in the past, addressed the cost issue. We started that in 1977. We are addressing it further now. We have a cost containment plan which we have implemented. And we intend, through the coalition movement and others, to approach this as much as we can; as vigorously as we can so that we can find ways that physicians can do exactly what you are asking us to do and suggesting that we do. To the extent that we can find ways to find these answers, to develop answers, we intend to do so. We are not trying to duck behind the statement that there is nothing we can do about it. That really isn't what Dr. Rainey meant. And that's not what I mean. And I hope you don't draw that conclusion from us.

Senator CHAFEE. No.

Dr. CLOUD. There is a lot we can do and we intend to address those issues.

Senator CHAFEE. Well, my problem is that there is no incentive for you to do it. If you do it, you are risking something. If you don't send out the lab tests, you might be sued for malpractice. There's every incentive in the world to use the system to its fullest extent because you aren't paying for it, nor is the patient paying for it. Some unknown entity way off somewhere in Washington or wherever it might be in Illinois is paying for it.

Dr. CLOUD. Well, thank you, Mr. Chairman.

Senator DURENBERGER. Mr. Chairman, thank you. Let me thank John for bringing up that issue. I was hoping your response would be that it's your patient who can help you hold down costs the most. Ultimately, it's the patient who is going to give you the incentives to provide the most cost-effective care. That is, if the patient ever gets any kind of choice.

Although ultimately I am in charge of my health care, as a physician, you are in charge of my sick care. You make many financial decisions for me, including what types of medical technology will be used to treat me or what medical facility will house me. Tell me, Dr. Cloud, how do physicians make these important financial decisions?

Dr. CLOUD. Well, Senator Durenberger, that depends on the choices that the physician might have. In some communities he doesn't have any choice at all. But I will tell you that one of the programs that we are emphasizing is to seek alternatives to hospitalization wherever that is possible. That's a very good thing to do in terms of ambulatory surgery, for example. In my own practice of pediatric surgery, I've found out in the last 10 years, that with a good ambulatory surgery care center available in Phoenix that I can do some 60 percent of my practice on an outpatient basis and avoid hospitalization. And save significant amounts of hospital costs. That is one example.

There are other ways to seek alternatives to hospitalization. It seems to me that with the cost of hospitalization being as high as it is, and I don't want to sound facetious, but the best way to avoid that cost is to stay out of the hospital. And that brings you back to alternatives to hospitalization, consumer choice. The concept of consumer choice which you alluded to a moment ago, which involves the patient in the selection of the payment for and the evaluation of his or her own care—and I hope will avoid, because of price consciousness, will avoid excesses and abuses in the system. I hope it will lead to that. And finally, prevention. Prevention is very important. And this is where the citizenry themselves can be effective. The prevention of all kinds of things that are laid upon us by people who undertake lifestyle activities and that cause preventable illnesses, which account for perhaps half, according to Federal estimates, of the total health care bill that we pay today is a major answer to raising costs.

And I hope we can make inroads into those areas so that we can hold down the utilization in such a way that we can control cost effectively. I think that's where the big dollars are for savings.

In addition, there are some other things that can be done. But when you get right down to it, if you become seriously ill and you do need to go in the hospital, then you need and you do deserve and should have the finest technology available. And that should be paid for. But we hope that we won't have so much unnecessary expense somewhere else in the system that it will not be possible to provide to everyone who needs that technology the opportunity to have it.

The CHAIRMAN. I want to thank Dr. Cloud and Dr. Rainey. We have a problem, as you can see. In fact, during one of the lulls in the committee hearings—they are generally so exciting you don't have any lulls, but now and again there are lulls—I was looking back over some testimony that HEW officials presented to this committee about 10 or 12 years ago. And they were predicting that if we didn't do something that medicare could rise to as much as $9 billion by 1990. It's $56 billion this year. It is headed for $113 billion. And we would hope that the AMA staff would run right back to the office and find us a few billion dollars that we could save.

Dr. RAINEY. Senator, I was just hoping that you ran across AMA's testimony during that debate when AMA said it is going to cost much more than you were anticipating.

The CHAIRMAN. We assumed that at the time, I guess. [Laughter.]

Don't misunderstand. I like physicians. Most of them have operated on me so I don't have any——[Laughter.]

And I've got the pathologist offering me free autopsies so I understand some of the problems. [Laughter.]

Dr. CLOUD. If you need a good pediatric surgeon, Senator.

The CHAIRMAN. Well, we're working on that, too, but——

Dr. CLOUD. I know one that is going to be unemployed. [Laughter.]

I will be available in about 3 months.

The CHAIRMAN. OK. A nice climate there. Thank you.

Dr. CLOUD. Thank you very much, sir.

Dr. RAINEY. Thank you.

The CHAIRMAN. We now have a panel of Bruce Cardwell, who is not a stranger to this committee. Bruce, we are happy to have you. He is the deputy vice president of Blue Cross and Blue Shield. And Burton E. Burton, senior vice president, Aetna Life & Casualty Co. Do you want Bruce to go first?

STATEMENT OF BRUCE J. CARDWELL, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS, CHICAGO, ILL.

Mr. CARDWELL. OK, I will be glad to go first. And, Mr. Chairman, out of respect for your concern for time, I will try to just briefly summarize my statement.

We appreciate the opportunity to participate in this discussion. Our purpose is to try to bring our perspective to the very difficult task that you have before you. But I would like to emphasize that as a part of the perspective the Blue Cross and Blue Shield organization has a great deal at stake. We are interested in the outcome because it has economic significance for us, but also it has very deep meaning as to our own sense of our social purpose.

We have to understand and share in the concern that the Government has for the budget. It has to clearly be brought into better balance. And we all have to do our best to help the Government to that end. But I have to say to you that I think the proposals that have been put before you by the administration in the area of medicare will not achieve their purpose. I do not think they will produce the savings that are being calculated. But more importantly, I think they are going to take us another step toward a basic distortion of the integrity of the program.

And the problem that we all have is that we have to face the fact that neither the private sector nor the Government have really come down on the root causes of the problem that we face. And we've been tinkering. We've been dealing in expedience. And what you have before you, I believe, is another list of expedience. But this time, I think they run the risk of doing some serious damage to the future of the program.

And before I finish, I would like to make a couple of comments about those parts of the proposals that I think have the greatest—offer the greatest chance of damage.

At the risk of being gratuitous, we would like to suggest to the committee that as you review these and other alternatives that you try to do it within a context, you should examine, we believe, each of them in terms of how they fit your view of what you want medicare to be. If you have decided that medicare really isn't affordable, then you have got to do something about the scope and reach of benefits, and the scope and reach of eligibility. Some of these cuts actually affect those basic program and policy elements, but they don't do it directly. They only do it indirectly. They parade in the name of efficiency, and doing something about containing the cost, but really their net effect in the long term, we believe, and in many cases the short term, will actually be to make decisions about the scope of benefits, and the scope of eligibility. And it will be more incidental than deliberate. But the result would be the same.

Finally, we think you should look at them in terms of their impact on the delivery system. As I said, we all have a stake in this. And I think there is one characteristic that runs through this list of proposals. It's that they tend to pass the costs onto somebody else. I know of no other customer in any market who could come into the market and say arbitarily—without negotiating—I don't like your price. And that's what many of these proposals say. We don't like the price. And we are not going to pay it. We are going to use the service but we won't pay you your price. We, using the force and leverage of law and regulation, will take the service and arbitrarily cut the price. All other buyers say that if I don't like your price, then I won't buy the service, or will cut down the scope of the service that I am seeking.

I would close by making two or three recommendations to you. First, that you concentrate, as quickly as you can and in this session if possible, on a perspective reimbursement approach. Also, that you emphasize those parts of the administrative process of medicare that deal with utilization review. And there is a proposal for the administration of the program to that end. Although I do not think it is adequately funded, from the point of view of contracting who will have to administer it, it is the right approach, we believe.

Finally, I think the committee ought to pay some attention to the administrative budget for medicare administration. We are quite convinced that it has now reached the point where the partnership between the Government and the medicare contractors is in doubt.

Thank you.

[The prepared statement follows:]

STATEMENT BY BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Mr. Chairman and Members of the Committee:

We appreciate the opportunity to appear today. Our purpose is to offer the experience and perspective of the Blue Cross and Blue Shield organization in your deliberations on the 1983 budget for Medicare.

There can be no doubt of either the difficulty or the importance of the task before you. In our opinion the decisions to be made have important consequences not just for Medicare and the people served by these programs, but also for the basic fabric and integrity of the private health care delivery and financing systems.

The problems of increasing utilization and rising costs are clearly not Medicare's alone. They are faced by all who depend on our health care system and all who have a role in its financial integrity -- ranging from employers, unions and insurers to individual citizens who buy insurance or who self-insure.

Mr. Chairman, we understand and share the cause of constraining the Federal budget. One way or another, it must be brought into better balance. But we feel compelled to say that we do not believe that the magnitude of savings proposed by the Administration can be achieved during FY 1983 in a manner which is responsible or fair to beneficiaries. We fear that the types of program savings which can be achieved in such a short timeframe would lead to fundamental changes which will make the program inferior for beneficiaries generally and totally inadequate for the poor.

We should pause to point out, Mr. Chairman, that we recognize the importance of budget actions aimed at more efficient management of the Medicare program. But, we believe that the process must be carried out within a public policy framework that clearly defines the short and long-range objectives of the Medicare program. We do not see such a policy framework as now being in place for Medicare.

Our recommendation at this time is that the proposals now before you be assessed in the broader context of:

1) Their effect on the basic objectives of Medicare: how they affect eligibility, benefits and beneficiary out-of-pocket costs.

2) Their impact on the rest of the delivery system in terms of whether they will truly influence cost containment, and whether they are consistent with the principle of the government paying its fair share.

To understand why we make this suggestion, it is important to examine what has happened so far and what is likely to happen if the 1983 budget actions are not evaluated within this broader context.

- First, limits and caps imposed through annual budget constraints and selective ad hoc legislative and regulatory actions of the past have not fulfilled either their short or long-term objectives. They have not prevented increased utilization or increases in basic costs.

- The limitations have not always been consistent in either their design or their effect. They have shifted back and forth in their effect on benefits, entitlements, and, in some cases, eligibility.

- At times, the actions have resulted in severe and abrupt increases in beneficiary out-of-pocket costs. For example, after years of deferring increases in the Medicare deductibles the 1982 budget included an abrupt increase -- an increase which has affected not just the out-of-pocket expenses of beneficiaries, but also their Medigap premiums.

The list could go on. But, what is important is to be aware of the uneven pattern of these actions and their effect on other parties at interest.

Many of the 1983 proposals represent a continuation of this pattern. We clearly are now at a point where the integrity of the program itself and the interests of the beneficiaries it serves are at risk. For example, the 1983 cuts would --

- Redefine eligibility for Medicare beneficiaries (from the first of the month a person reaches 65 to the first of the next month). The question is whether this change would be consistent with overall policy on eligibility.

- Shift previously covered costs to employers of the elderly at a time when the Social Security system suggests longer attachment to the work force.

- Establish a 5 percent coinsurance for home health benefits -- another increase in beneficiary out-of-pocket costs.

- Delay updating physician fee screens. This will mean fewer assignments and will result in cost transfers to patients.

- Finally, the 1983 budget introduced the 2 percent reduction in Medicare reimbursement to hospitals.

Under the latter proposal, Medicare would refuse to pay 2 per cent of the costs (Medicare-defined costs) actually incurred by its patients. There is not even a rationale of creating incentives for increased efficiency; the most efficient hospitals also lose 2 per cent. Moreover, we believe that such a proposal will ultimately lead to what we consider an undesirable public policy -- allowing hospitals to surcharge patients. We believe that allowing hospitals to surcharge beneficiaries would result in the government losing all ability to exert pressure against hospital cost increases, and in rapid deterioration of the Hospital Insurance Program to a second class program.

Mr. Chairman, another area of savings recommended by the Administration I would like to comment on briefly is the proposed reductions in funding for Medicare contractors operations. This expenditure is not within the jurisdiction of this Committee, it is subject to yearly review of the Appropriations Committee.

It is clear, however, that the present inadequate budget for Medicare contractors means this committee will have to contend with larger program payments next year.

Because of recent severe reductions in the budget for contractor operations intermediaries and carriers have, at the direction of the Health Care Financing Administration, had to terminate or curtail a number of functions which control the expenditure of benefit dollars. Medical and utilization review, which is the best front-line defense against program abuse and fraud, has been virtually eliminated. Audit activities, which yielded a 26 to 1 savings ratio in FY 1981, will be reduced substantially in FY 1982.

We believe that without these safeguards, benefit dollars will be passed through and will be compensated for in future years by increased patient cost sharing and further reductions in provider reimbursement.

Mr. Chairman, the Blue Cross and Blue Shield Associations recognize that the need to control Federal spending generally and the need to make efficient use of the Medicare trust fund dollars make it imperative to examine ways to slow the rate of growth in the program. We believe, however, that a public policy framework is necessary in order to judge financing and other structural changes in the program. Such a framework, we believe, should include:

1) A principle of balanced reimbursement of all appropriate costs traceable to the Medicare beneficiary population; and

2) Clear-cut and updated concepts of eligibility and coverage, both short and long-term.

Once a public policy is agreed to for these two areas, Congress can then move to policy changes directed toward true cost containment. For example, we believe that major savings can be achieved, over time, through such activities as improved utilization review and use of prospective reimbursement schemes. These two areas have been discussed and debated before. But, they still represent the best opportunities we have to change the behavior of the marketplace. Blue Cross and Blue Shield Plans have much experience in these areas and would be delighted to share our expertise with the Congress.

I would end by saying, however, that prospective reimbursement and improved UR programs represent fundamental changes that will take time to develop and implement. We do not believe savings, of the dimension this Administration is requesting, can be enacted within the framework of the FY 1983 budget and still preserve the primary and longstanding objectives of the program.

STATEMENT OF BURTON E. BURTON, SENIOR VICE PRESIDENT, AETNA LIFE & CASUALTY CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

The **Chairman**. Mr. Burton.

Mr. **Burton**. Mr. Chairman, my name is Gene Burton, senior vice president of Aetna Life & Casualty. And with me is John Ahearn, counsel. And we appear today on behalf of the Health Insurance Association of America and the American Council of Life Insurance.

We rarely second the views of our competitor, Blue Cross/Blue Shield, but in this instance, I think you will see that our testimony is generally parallel in its concerns and in its recommendations.

Our business really does understand and sympathize with your committee's concern about the Federal deficit. We are completely supportive of an idea of containing health care cost, which we have been quite active on for a number of years. But, we feel we must oppose the idea of a 2-percent-across-the-board reduction in medicare reimbursements to hospitals or any other arbitrary cuts in payments to providers.

This move would not reduce system cost, but it would merely shift more cost to private patients, including Federal employees. The 2-percent solution highlights what has been going on for many years—a continuing ratcheting down of medicare reimbursement levels, taking one opportunity after another to redefine what medicare chooses to pay for. This hidden tax on private patients already amounts to something like $5 billion. And we think it would increase substantially if the 2-percent proposal is approved.

The **Chairman**. You say $5 billion?

Mr. **Burton**. Five billion. That would be our industry's estimate of its magnitude today. If the cost of medical care is growing too fast, then it's growing too fast for all of us. We believe the Government has a responsibility to look at the results of its actions on the entire system, and not just on the Federal budget.

The 2-percent solution cannot be justified either by representing it as a behavior of a prudent purchaser. The Government, we don't believe, is shopping judiciously for price or quality. It's using economic power that comes from the hospitals' dependence on Government payments.

We also don't believe that this proposal is cost containment. It's just another increase in the rate of escalation of charges for private sector patients.

Hospitals, if the 2-percent solution is adopted, have no choice but to accept it. They have an obligation to serve the poor and elderly, and we believe they will do that. For prosperous hospitals with enough charge-paying patients to whom to shift cost—the arbitrary cuts may be preferable to more complex rule changes. But, the 2-percent solution hits all hospitals across the board. The inefficient as well as the efficient; lean as well as fat. And we think it would be particularly hard on certain hospitals, those that have a high proportion of public program patients, charity cases or a high volume of bad debts.

If an arbitrary reduction is going to be made, there should be some mechanism for sharing that burden equally among hospitals.

Congress acted wisely, last year, by directing the Department of Health and Human Services to devise a system of prospective hospital reimbursement. We strongly support that idea, provided that it adequately recognizes the realistic revenue needs of hospitals. If it is properly designed, it would reward hospitals for efficient behavior and for cost containment. But, if the system is not based on realistic revenue needs, then cost shifting would continue to occur. And most of the advantages of prospective reimbursement would be lost because there would be no incentive for efficient behavior.

But the system, at least in that case, could be designed so that any medicare approved hospital would allocate any shortfall in Government patients equally among all private patients. Then any cost shifting that does take place would at least be borne equally within the private sector.

A much better approach has been developed in some States which have acted on their own to deal with rising costs. These States are Maryland, New Jersey, and Illinois. And in those States there is enabling legislation giving hospital rate setting authorities jurisdiction over the rates paid by all patients, including payments for Federal patients. These programs have worked.

Here we recommend a combination of State and Federal initative. Congress could develop criteria for qualified State prospective reimbursement systems that include all payers, private and public. The idea can be implemented, we think, by a simple amendment to last year's Omnibus Budget Reconciliation Act. Right now, only States that had adopted qualified cost containment programs before July 1 of last year are eligible for partial restoration of the medicare cutback. But this incentive, together with qualifying criteria, should be made available to encourage more State action rather than less.

May I continue for just a second?

The CHAIRMAN. Yes.

Mr. BURTON. Also, Mr. Chairman, insofar as the proposals for a change in medicare responsibilities for the working aged, we think the proposal has merit. Our industry would not oppose that idea. And we would be happy to work with the committee in trying to examine the feasibility of such an approach.

This time of heightened concern over the budget presents all of us with an opportunity to think long range, and to think about the fundamental relief for medicare. Nothing less perhaps, than the entire stability of the health care system is at stake.

So I close with those comments, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND THE AMERICAN COUNCIL OF LIFE INSURANCE PRESENTED BY BURTON E. BURTON

My name is Burton E. Burton. I am Senior Vice President of the Aetna Life and Casualty Company. I appear today on behalf of the Health Insurance Association of America and am joined in this statement by the American Council of Life Insurance.

Any enterprise, if it is to survive, must recover the costs of producing goods and services. Both fixed and variable costs must ultimately be reflected in the prices consumers pay. If one segment of a business suffers losses, then these losses must be offset by gains elsewhere. Otherwise, the entire enterprise will fail.

Hospitals, physicians, and nursing homes are no exception to this rule. Federal and state governments unfairly restrict their payments to health care providers, paying only part of the hospital costs of Medicare and Medicaid patients. When the government refuses to pay its full share, everyone else must pay more. Costs not covered by Medicare and Medicaid for their patients must, therefore, be recovered from private patients. It is, in effect, a hidden tax on sickness, levied on a hospital's non-government patients to pay those hospital expenses not paid by Medicare.

Despite widespread concern about rising health care costs, little attention has been focused until recently on the practice of cost-shifting from the public to the private sector.

This is how it works. Under the payment formulas established by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, certain hospital costs are not recognized. These include:

- The bad debt and charity costs incurred in treating patients who do not pay their bills.
- Certain equity capital requirements necessary for replacement and addition of facilities and equipment.
- Certain hospital educational and research costs.

At the same time, the government has progressively tightened its regulations for determining reimbursable costs. Section 1816 of the Social Security Act states that "reasonable cost shall be determined by regulation which may provide for the establishment of limits on the direct or indirect overall incurred costs . . . to be recognized as reasonable." These limits have been repeatedly lowered. As a result, the "hospital payment differential," that is, the difference between what Medicare and Medicaid choose to pay and what private sector patients pay, continues to grow year by year.

Mr. Chairman, the Congressional Budget Office last year stated that Medicare pays, on the average, 16% less than the average non-government patient. This, as troublesome as it is, of course, understates the problem in many areas. I can only call your attention to the man who drowned in the river which was only one foot deep -- on the average.

We believe strongly that, if a hospital has two patients, side by side, receiving the same care, in identical circumstances, it should receive the same payment regardless of who the payor is.

The situation is growing worse, not better. From 1975 to 1979, the differential rose from $12 to $41 per adjusted patient day, an increase of 242 percent. Based on this rate of growth, the difference will rise to $140 per adjusted patient day in 1983.

Stated another way, on an average daily basis in 1979, Medicare payments were $198 while private patients were charged an estimated $239 for the same service. Overall, the shortfall in government payments increased from $1.1 billion in 1975 to $3 billion in 1979. Moreover, the Health Insurance Association of America (HIAA) now estimates that the 1981 shortfall will exceed $4.8 billion. This gap will surely widen if Congress approves a 2% across-the-board reduction in Federal reimbursements to hospitals for Medicare patients.

Faced with this shortfall in revenue, hospitals have two choices. They may draw upon available hospital reserves, if any, to make up the deficit or they must overcharge patients who are not under government programs. Most hospitals adopt the second option to preserve their fiscal integrity. Thus, government reimbursement practices lead directly to differentials in payment between government and private patients. The end result of lower Medicare/ Medicaid payments is cost-shifting to private patients, not cost containment.

These growing shortfalls are hurting hospitals, hampering employer efforts to contain health care costs, and inhibiting the potential for further developing competition in the health care system.

Many inner-city and rural hospitals with a high proportion of Medicare/Medicaid-cost-reimbursement patients have extraordinary shortfalls and differentials. At these hospitals, there are fewer patients who pay full charges, and the hospitals are unable to shift their losses to private patients. Consequently, it is not surprising that some of these institutions are already in financial distress, and the 2% reduction could be the final blow. One hospital administrator expressed the dilemma to us this way:

"Today, at Greater Southeast Community Hospital (in Washington, D.C.), a patient who is hospitalized for five days and who undergoes surgery will incur the same charges or bills -- but the hospital will be paid the following: D.C. Medicaid, $2,401; commercial insurance, $3,184; Blue Cross, $2,881; Maryland Medicaid, $2,675; and Medicare, $2,520.

"That's a 25 percent spread on one bill. This inequity punishes hospitals and patients alike, particularly middle-class patients who must subsidize the below-cost reimbursement of Medicare and Medicaid." (Barry A. Passett, President of the Foundation which oversees Community Hospital in Washington, D.C.)

Arbitrary reductions in government reimbursements do not encourage hospitals to economize to meet lowered payment schedules. Instead, once hospitals begin shifting costs to the private sector, increasing charges becomes a logical and routine response to government reimbursement limitations.

Clearly, the severity of the problem restricts competition in the health care marketplace. Stated very simply, private payors cannot compete with Medicare (for example, through a voucher system) when the government buys at less than full cost 40 percent of the nation's total hospital services. Hospitals cannot compete on the basis of price when their payments are arbitrarily reduced for a large percentage of their patients. Furthermore, in certain areas of the country, commercial insurers are virtually unable to compete with Blue Cross plans because of Blue Cross contractual arrangements to pay hospitals less than they must charge other private patients. In those areas where the Federal shortfall is not spread evenly across the non-government patients, the problem is, of course, exacerbated.

Mr. Chairman, the designers of Medicare believed at the outset that by paying only for the actual cost of treating government-program patients (i.e., the "cost payment" method), hospital reimbursement would be effectively controlled. It soon became apparent that the cost-payment method, which provided for retrospective payment of all recognized costs, did not result in the desired accountability.

On the contrary, because the costs were adjusted by being paid retrospectively, hospitals were not at risk financially and, therefore, had little incentive to hold down costs. What reward did a hospital administrator get who worked hard and did, in fact, lower his costs? Less money. A reduced cash flow. Is it any wonder that Medicare/Medicaid expenditures began to outstrip general inflation in the economy?

What of solutions? The Congress made a beginning last year when it directed the Department of Health and Human Services, in Public Law 97-35, to devise a system of prospective reimbursement for hospitals suitable for both Medicare and Medicaid. We strongly support the development of a prospective reimbursement system that is equitable to all payors and provides hospitals with rewards, not penalties, for more efficient behavior.

Other steps toward a solution have already been taken in a few states. Examples are Maryland, New Jersey, and Illinois. Enabling legislation in these states gives hospital rate-setting authorities jurisdiction over rates paid by all private sector patients.

In addition, these authorities have obtained approval from the Federal and state governments to establish comparable rates for Medicare/Medicaid payments. Such approval was obtained under Section 222 of the Social Security Amendments of 1972. This section allows the Secretary to waive the usual reimbursement regulations in order to experiment with prospective payment systems.

By participating in the waiver system, Medicare and Medicaid agree to reimburse for certain services for which they would not otherwise pay. In effect, therefore, they would pay on the same basis as private insurers.

On the surface, such concessions would appear to be more costly. Medicare and Medicaid, however, are willing to participate in prospective payment systems under the waiver authority because these systems provide positive incentives for reducing overall hospital cost escalation and thereby generate cost savings.

These incentives result because this system prospectively approves a hospital's budget, thereby determining in advance needed hospital revenues which will form the basis of payment by all patients.

In this way, hospitals are encouraged to achieve savings by increasing their operating efficiency. By reducing operating below approved revenue levels, a hospital can produce a surplus that can be used at its discretion. It can be applied to new programs, services, or simply contributed to the hospital's reserves to help assure financial stability.

It should be pointed out that a waiver includes inside limits on the government's liability. Operating with a Medicare/Medicaid waiver, Maryland has achieved both equity among payors and government payments that are at least as low as they would have been in the absence of the program.

In the three years of 1978, 1979, and 1980, the Medicare and Medicaid program saved a total of $86.5 million in Maryland compared to what total expenditures would have been if that state's program did not exist.

Mr. Chairman, the HIAA is completely supportive of the Administration's goal of controlling inflation. No industry is hurt more by inflation than the insurance industry. Our support for cost containment measures in the health field has been second to none. Most recently, in January of this year, the HIAA joined five other national organizations, including the AFL-CIO, the Business Roundtable, Blue Cross-Blue Shield, the American Hospital Association, and the American Medical Association, in a joint statement calling for the development of health care coalitions on the state and local level as an important means of restraining costs and improving the quality and access to care. However, it must be clear from the foregoing that the HIAA must oppose the 2% across-the-board reduction in Federal reimbursements to hospitals for the care of Medicare patients, as well as any other arbitrary cuts in payments to providers which do not in reality represent true program cost reductions but are merely the shifting of present costs to other patients.

The 2% solution shows in stark reality what has been going on for years, a continuing ratcheting down of Medicare reimbursement using one excuse after another to re-define "reasonable cost." There has always been an excuse, a reason, but the result has always been the same -- another ratchet down.

If the cost of medical care is too high, it is too high for all of us. It is simply not fair for the government to solve its problem by fiat and leave the rest of us to pick up the pieces. It has a responsibility to look at the results of its actions on the rest of the system.

The "2% solution" is not being a "prudent purchaser." It is not picking and choosing from whom it will buy, shopping judiciously for price and quality. It is using naked economic power that comes from the hospital's dependence on government patients and the full power of government to arbitrarily reduce its expenses across the board, take it or leave it.

Nor is the proposal cost containment, as many would have us believe. It is a step toward cost escalation and has a direct impact on not only hospitals, but employers and private-paying patients, who ultimately must bear the burden of spiraling health care costs.

And, as a practical matter, the hospitals, if it is enacted, have no choice but to take it. To those hospitals which are prosperous, and have plenty of charge patients to shift the cost to, it may be an excellent solution, preferable to razzle-dazzle rule changes that increase administrative costs and red tape with the same result. But the 2% solution hits all hospitals across the board, efficient and inefficient alike, lean as well as fat. The result must, in fact, be inordinately hard on those hospitals with a high proportion of Medicare and Medicaid patients, or a large proportion of charity cases or bad debts.

There are, on the other hand, practical steps to reduce program costs which we do not oppose. We would support bringing all Federal employees under the Medicare system, since many qualify for it already.

We do not oppose making Medicare secondary to employee group insurance for workers over age 65, nor do we see any practical problems with delaying the initial eligibility date for Medicare beneficiaries.

There is a broad agreement that the status quo is unacceptable. Indeed, research reveals a high degree of public concern with the problem. Though there may be difficulties in implementing corrective action -- and even a lack of unanimity on the best option -- the future stability of the health care system demands that the problems caused by cost-shifting be recognized, addressed and resolved in the public interest.

Mr. Chairman, on the subject of containing the rising cost of Medicare, there is another issue of vital importance -- the Medicare competitive contracting proposal and the overall budget crisis facing the intermediaries and carriers.

You are undoubtedly aware that total Medicare payments to hospitals, doctors, and other providers will come close to $50 billion dollars in 1982. Medicare payouts have increased by more than 20 percent each year since FY '80 and threaten the entire Federal budget.

I mention this because private insurance companies not only have the responsibility for paying claims efficiently, but also must assure that claims on the Trust Funds are legitimate, appropriate, and reasonable. The intermediaries and carriers have performed this function on a no-profit, no-loss basis since this partnership for Medicare Administration was formed in 1966. This method of joint administration which costs only 1.7 percent of the whole program, has been a major success and serves as a model for how complex public programs can be managed.

In this context, the competitive contracting proposal sends us another signal that too many people are focusing on the 1.7 percent rather than on the $50 billion. In 1972 it cost 3.4 percent of the total program for administration. Today that figure has been cut in half. Our record for consistently lowering the cost of claims administration despite inflation and increasing workloads is clear.

However, the budgets for Medicare Contractors for FY 1981, 1982, and now proposed for 1983 are so seriously under-funded that they jeopardize the partnership built so carefully over 15 years. The tail is wagging the dog. Budget cuts have forced us to give up the trained professional personnel we need to adequately supervise the $50 billion in program payouts. If the Medicare carriers and intermediaries are to continue to do the job expected of them, they must be adequately funded. To do otherwise is penny wise and pound foolish on an unprecedented scale.

Thank you.

The CHAIRMAN. Well, thank you very much. Again, I don't disagree. I don't think the 2-percent solution is the solution either, but we still have the budget problem. And it is not long range. It's about to explode. You know, maybe we made a mistake in not supporting President Carter's mandatory cost containment. Many of us opposed that because the hospitals, we were told, were going to have this "voluntary effort" that would take care of all those things. I'm certain we will hear witnesses later who can justify the 19-percent increase in hospital costs. Maybe we ought to go back and look at that approach. Could you support that? A mandatory cost-containment program.

Mr. BURTON. I guess we would come down to it as a last resort. We went through that process a year or two ago. We think we ought to try some other things first.

The CHAIRMAN. Well, I did too, but we don't get any suggestions. Everybody comes in and says they are all glad to be here to address the long-term problem in about 10 years. Well, there won't be anybody around in 10 years if they don't address the short-term problem.

Mr. BURTON. Well, Mr. Chairman, I think we could start in that direction with this prospective reimbursement idea, both at the State level and with some Federal initiatives to bring that about.

The CHAIRMAN. But, how quickly could we start? In fiscal 1983?

Mr. BURTON. I'm sorry.

The CHAIRMAN. Fiscal year 1983, for example?

Mr. BURTON. It would take some time for the States to act. But with the proper incentives, something could be forthcoming soon in some States at least, I assume.

The CHAIRMAN. Mr. Cardwell.

Mr. CARDWELL. I have to be very frank with you. I don't think you could set an effect of prospective reimbursement system in place in time to help the 1983 budget. Maybe the very outer edge of it at best. But, I still think it's the thing to do, and the sooner the better.

On your basic question of mandated hospital cost containment, I would have to tell you I don't think in the long term will work any better than any other top down mandate. I don't think you can mandate market behavior. Most people think this is not a marketplace, but it really is.

The CHAIRMAN. Well, not really because there isn't much competition.

Mr. CARDWELL. Well, but it is nevertheless a marketplace.

The CHAIRMAN. Nobody ever sees the bill.

Mr. CARDWELL. It may be but it's being influenced by forces. Senator Chafee mentioned some of them during his discussion with the AMA spokesman.

When a doctor is at risk in face of malpractice, he takes steps to protect himself against that risk. And that costs money. And that money is passed onto medicare, and it's passed onto the private side as well. That is a market force in this particular activity. And I don't see anything in a mandated hospital cost-containment system that deals with that fundamental problem.

What we are trying to say to you that it isn't enough for the Government, the Congress and the executive branch to just from year to year deal with the expedience of this ratchet or that ratchet. We are not facing the fundamental issue which is that we do not find medicare to be affordable under the present marketplace arrangement. And, we are not doing anything to change the marketplace behavior, and we are not doing anything to really contain the dimensions of the program. And until you work on those two sides of the equation, I think you will be here every year, year in and year out, going through the same discussion that we are having here.

The CHAIRMAN. I don't quarrel with that. I think we are beginning to address the long term. But, we also have some short-term problems. You call it "ratcheting;" we will call it ratcheting. But, I just believe that if we throw up our hands and say we have had all this testimony from the people who profit and benefit; they don't want to do anything so we are not going to do anything. We will just take it out of the food stamp program; take it away from the poor people.

Mr. CARDWELL. Well, I think some of the changes that are before you will have the consequence of taking money out of the hands of poor people. Others won't. The idea of changing the month of eligibility for Medicare, moving it from the first month after the age of 65, follows the path of commercial insurance. And in that sense, it is quite consistent. It doesn't disturb the benefit equilibrium. And it doesn't transfer cost to anybody. However, it doesn't deal with that lot of the elderly who are not working, and who don't have private coverage. In that case, you have deliberalized their benefits. But you didn't tell them you deliberalized their benefits. What you told them was that you were closing a loophole in the basic administrative fabric of the medicare program. That's what we are trying to say to you. Look at each of these items and make a judgment about it. That one is one where we think a reasonable judgment could be made to adopt a proposal.

We think the 2-percent proposal is essentially arbitrary. And it's justified on the argument that hospitals are inefficient, and they charge too much. It isn't going to do anything to change their efficiency. In fact, the most efficient of the hospitals would suffer the 2 percent along with the least efficient.

The CHAIRMAN. I share that view. But you do understand we do have a problem?

Mr. CARDWELL. Yes, indeed we do.

The CHAIRMAN. You won't object too loudly if we try to address it?

Mr. CARDWELL. We would like for you to address it.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you very much. On the last point you made, Bruce, relative to addressing the proposals on the so-called working aged, it has been suggested to me that the administration's savings have been exaggerated for that particular group of people because they are probably the healthiest of the aged. Is that true in your judgment?

Mr. CARDWELL. I will have to say to you that every savings item you have got on that list is exaggerated. And I say that from a background of having myself exaggerated similar estimates. [Laughter.]

Senator DURENBERGER. All right. I think you are getting the message that we need help on both. If we are going to solve the long-term problems we also need some short-term help.

Gene, are you saying on behalf of the Health Insurance Association that you favor capitation of medicare?

Mr. BURTON. I'm sorry.

Senator DURENBERGER. Do you favor capitation or vouchers or some other approach to medicare?

Mr. BURTON. I think what I said was that we thought you should look at the proposal for the working aged where you would have medicare be supplemental to private insurance coverage.

Senator DURENBERGER. Do you have an opinion on capitation of medicare, the John Heinz proposal, or the administration's proposal?

Mr. BURTON. Yes. As far as the medicare voucher proposal is concerned it just won't work, for the very cost shifting problem that we are talking about today.

Senator DURENBERGER. That's consistant with the answers we've gotten in the past from the Health Insurance Association. When asked about competition and consumer choice, your answer is that because there are 500 insurance companies out there competing with each other, and 50,000 agents competing with each other, we don't need consumer choice and competition. Have you changed that position in the last year?

Mr. BURTON. No, we have not. We haven't changed the position that procompetition alternatives, as presently set forth, won't work.

Senator DURENBERGER. I didn't hear the last part of that.

Mr. **Burton**. Well, our position is that the procompetition idea of achieving cost containment through low cost optional choices of plans—is froth with difficulty, and unlikely to achieve the objectives.

Senator **Durenberger**. All right. We have now addressed two of the major long-term proposals that have been supported or questioned by a lot of people. As the subcommittee chairman, let me ask, what are you going to do about this? You oppose shifting cost; you oppose choice; you oppose competition; you oppose capitation. What's the Health Insurance Association of America's answer to the high cost of health care?

Mr. **Burton**. If there were an easy answer to that question, we wouldn't be here today. I think we really have to start with the long-term fundamental reform ideas.

Senator **Durenberger**. Well, I have just given you some long-term fundamental reform ideas. What long-term reforms do you support?

Mr. **Burton**. Well, there are a number of things that can be done. In all parts of the system, there is some responsibility. You can look at insurance plans and you can say they are too liberal. And they are in many cases. There is not adequate consciousness on the part of patients regarding the cost of what they ask for. Things could be done in this area more directly than the procompetition legislation suggests. For example, there could be incentives, direct incentives, for more employers to put more cosharing and copayment arrangements into insurance plans.

Insurance companies, perhaps, could do more in that same direction. We are doing a lot of experimentation. You may have heard about a plan my own company is involved in called CHOICE, with Evanston Hospital in Illinois. We are trying to use the physicians' commitment idea, which I know you support, Senator, to bring about cost containment in a specific program. We think that has some merit and some appeal and many companies are doing a lot in that area. They are sponsoring HMO's and similar arrangements.

Senator **Durenberger**. Bruce, do you have a different answer?

Mr. **Cardwell**. Well, I think my answer may be a little different. As far as Blue Cross and Blue Shield is concerned, we think there are circumstances under which underwriting by the private sector insurance system would be feasible and workable. There are circumstances under which a capitation or vouchering program could be made to be workable.

What we fear, though, is that we will repeat the past. That we will lurch into changes of that kind with expectations that are not realistic. That the Government will do it, driven largely to save money for the Government. And that if it is bound and determined to do it for that reason, and only that reason, I doubt that any of those approaches would work. I don't think the Government is prepared to face up to the phenomenon of it having already obtained a very, very substantial discount in its purchases in the marketplace. And I don't think the private underwriting system could match that discount in the near term without passing some cost over to the beneficiaries. That might be good public policy, but I'm concerned that our lawmakers and the President, whoever it might be when it comes time to sign such a bill, will characterize it as solving the *health care delivery cost problems.* And walk off and leave it. And if that happens, I think you have just substituted one set of problems for another set of problems.

In other words, it really depends on the practical, realistic design of such systems. And the concepts are workable, but I am concerned about the political process as it works them over. If you produce a bill that says you can't raise charges to the beneficiaries, you have to mandate certain lines of coverage, and you have to save the Federal Government $30 billion in the process, you have not passed a realistic law.

The CHAIRMAN. Senator Chafee and then Senator Long.

Senator CHAFEE. Mr. Cardwell, you say on page 5 of your testimony:

> Medical and utilization review, which is the best front-line defense against program abuse and fraud, has been virtually eliminated.

I asked the Secretary of HHS the other day about that. He said that this characterization is not so. That the medical and utilization review is a perfectly acceptable share under medicare to compute into the cost of the institution. Is that true or false?

Mr. CARDWELL. Senator, it is basically true in terms of recognizing that as a cost of the institution. However, that remark, in my statement, refers to the fact that in the funds for administration of medicare, payments to carriers and intermediaries—they have taken in the last 2 years—they have taken funds out for medical review out of those budgets and said don't do anymore medical review.

Senator CHAFEE. The fiscal intermediaries?

Mr. CARDWELL. Yes.

Senator CHAFEE. Shouldn't do any.

Mr. CARDWELL. Well, the Health Care Financing Administration and the Secretary of Health and Human Services have compressed the budgets of those contractors to a point where there is no money for that particular purpose. And they made a conscious choice to pull back on that. The next thing they are pulling back on, and that's in the process of occurring right now, is on auditing of the hospitals themselves. If you cut those two activities back, you are just going to ultimately drive up expenditures under the program. And the budget might look good in the short term but not in the long term.

Senator CHAFEE. What I deplore about this system is the lack of incentives. Last month I visited the Trans-America Occidental operation out in Los Angeles where they care for one-half of the medicare patients in California, roughly. They indicated that their cost per claim was $2.10 for processing each claim, which was the lowest cost of any fiscal intermediary in the country. I asked them what rewards they got for this. They received reward. There is no financial incentive for doing this except to claim that they are No. 1. However, if they were No. 3, they would have no reward whatsoever because I don't think there is much mileage in claiming you are No. 3.

Mr. CARDWELL. Oh, yes, there is. When you get down to No. 40, that's when the disincentive comes. There are a lot of disincentives.

Senator CHAFEE. All right. What financial incentive is there for a fiscal intermediary to cut its costs in processing each claim?

Mr. CARDWELL. I think there are some incentives.

Senator CHAFEE. What?

Mr. CARDWELL. OK. The most important one is a system of productivity and performance measures. And as carriers' intermediaries are rated annually against those measures, and they are designed to measure efficiency—although I think the particular ones were using a very faulty, the idea is right,—that measurement process alone puts the contractor under considerable pressure to improve his performance and to improve his efficiency. That's the first one.

Senator CHAFEE. You haven't named the financial reward yet.

Mr. CARDWELL. OK. I'm going to get to that in a minute.

I think the second incentive is the peer relationship. How a carrier intermediary seems to compare with a would be competitor or with his peers in the same general area of activity.

Finally, you have to recognize that both the commercial carriers and intermediaries and the Blue Cross and Blue Shield carriers and intermediaries enjoy an economic advantage if they carry that role. A share of their overhead is at stake. A share of their basic capacity to carry on their general business.

Senator CHAFEE. But they have that if they've got the business.

Mr. CARDWELL. Yes.

Senator CHAFEE. They don't get any added reward if they bring that cost down from $2.44 a claim to $2.10 a claim.

Mr. CARDWELL. But keeping the business is an economic incentive.

Senator CHAFEE. Yes, but do people lose the business? When was the last fiscal intermediary knocked out?

Mr. CARDWELL. Illinois lost a very large business. We are in the midst at this time in Blue Cross and Blue Shield of consolidating some of our smaller intermediaries in order to——

Senator CHAFEE. Well, Illinois was an unusual situation where there was a bidding contest. And didn't Ross Perret's group get it?

Mr. CARDWELL. Yes.

Senator CHAFEE. That seems to me as separate.

Mr. CARDWELL. I guess the last one I would give you would be Memphis, Tenn., in medicare.

Senator CHAFEE. Thank you.

The CHAIRMAN. Senator Long.

Senator LONG. I'd just like to say a couple of things. One of them is that this 2-percent solution standing alone, in my judgment, just doesn't make any sense at all. In other words, would you say, well, here's what we recognize this to be your cost, but we are only going to pay you 98 percent of it. All that means, as has been suggested by you and other witnesses, is that you have got to charge your other customers, you have got to charge the other sick people enough money to make back the 2 percent that you are losing here. Isn't that right?

Mr. BURTON. That's right.

Senator LONG. I think we can all agree on that. So that then means that those who are somewhat better able to pay, when they go to the hospital, they have to pay more than they would otherwise pay. Now, of course, when you go to the hospital, you are sort of hard pressed for income anyway. That's the time when you get in the worst of it. Your income is down and your expenses are up. So to put a hidden tax on people when they have to go to the hospital is about the most illogical thing that I could assume. If I am going to have to pay a tax to support something, I would a lot rather be paying the tax while I am up and working and having regular income coming in than when I am nonproductive and have exceptional expenses and when the family has a heavier burden to carry. I think we can all agree, can't we, that a tax on the sick is about as illogical as anything that we can conceive of? A tax on being sick.

Mr. CARDWELL. We would agree.

Senator LONG. That's what it works out for as far as all those middle income people are concerned to paying the full tab.

Now the thought occurs to me that there are some ways where we could help other than just to raise the tax. I personally think that just standing alone that it is better for us to raise the money somewhere else and just take care of it. The tax, whatever tax it may be. But we can help in other respects. Mr. Cardwell probably has more experience than any of you. But it seems to me the administration is working on it and they ought to quit thinking about it after a while and come up with a plan where we would use more of these welfare clients to produce some useful work. I think the answer to it is not—I don't like the community work program just for the reason that it projects the idea that you have already paid these people, paid a grant to them, and now you are making them work after the fact. I think it is far better to take the view that we pay money to day care centers—we are doing that. We cover almost 100 percent of the cost, by tax laws and others, by making funds available to day care centers to hire welfare clients. It seems to me that we could say that we will pay you to the extent that you can hire some of those people to come work. Now what I think you need to do to make that work is you need to cut down on what you are giving people for doing nothing.

I read a story in the Post the other day that these welfare people don't make any more working than they do just sitting there drawing the benefits. And the reason is because you hand all that money out without requiring that they do any work for it. The something for nothing program is altogether too generous. It seems to me as though if you just took some of that money and provide a lot of jobs, marginal though some of them may be, and just pay the hospitals some money and say, all right, now you hire some of these people. And to the extent that you are hiring people off of these welfare rolls, we will just pay if not for 40 hours for 20 hours. But on some basis to hire those people to do some work. And hospitals could be useful. I just wondered what your thought is about that.

Mr. CARDWELL. I think that would be a question better put to the American Hospital Association. I don't think we are in a position to help you.

Senator LONG. Well, thank you. [Laughter.]

I'll wait.

The CHAIRMAN. Senator Byrd.

Senator **Long**. I didn't expect to see you duck on that, Mr. Cardwell. I thought with your broad experience you would have an opinion. [Laughter.]

Senator **Byrd**. What is the average cost per day for a hospital patient?

Mr. **Cardwell**. I couldn't tell you. It probably averages in excess of $200. We could furnish it for the record.

[The information follows:]

The average estimated cost per day for a hospital patient in 1980 was $261—calculated from the American Hospital Association's Annual Survey.

Senator **Byrd**. In excess of what?

Mr. **Cardwell**. I think it probably runs in excess of $200 a day. I haven't tracked it lately.

Senator **Byrd**. Well, I would think that your organization would be right on top of that figure.

Mr. **Cardwell**. Well, executive vice presidents pay attention to other things. But we have a very strong incentive at the plan level to be concerned about the cost per day. I agree.

Senator **Byrd**. The Secretary of HHS said a couple of days ago that it is $245 a day.

Mr. **Cardwell**. That's probably right.

Senator **Byrd**. And I would assume that you would concur that it is headed upward?

Mr. **Cardwell**. It seems inevitable that it's headed upward. The question I think before us at the moment is whether the rate of incline will decrease. I think it will. But you have to recognize that it was a very rapid rate during the last 2 years.

Senator **Byrd**. I'm not speaking of the rate of incline, I'm speaking of whether or not in your judgment it will increase.

Mr. **Cardwell**. As a matter of fact, it will go up. Yes.

Senator **Byrd**. Well, it seems to me that something has got to give. I don't pretend to know the answer to it. To have a hospital or a patient to have to pay $245 a day for hospital service just to be in the hospital is getting way out of line. Now I haven't heard any suggestions, and I wasn't here the entire time, I must say—but I haven't heard any suggestions from any of you as to how this can best be curbed.

Mr. **Cardwell**. Yes. I thought we suggested that prospective reimbursement and improved utilization review would both help.

Senator **Byrd**. There was one suggestion made that the employers could pay more of the cost. But that doesn't contain the cost.

Mr. **Cardwell**. No. That's right. In terms of getting at the root cause of rising cost of medical care delivery, our testimony tries to emphasize the fact that we don't think that we are getting to it. And that I personally doubt that you can get to it through the budget process.

Senator **Byrd**. What is the root cause?

Mr. **Cardwell**. It's a whole source of factors ranging from the behavior of consumers, behavior of physicians, behavior of the courts in the malpractice phenomenon. The American idea of health care is very fundamental. It's a very high priority in the minds of the citizens. As Senator Long pointed out, that's a terrible time to start bargaining for a price. Our idea that we must do everything in the power of the profession to save us all, to maximize the opportunity for care, to minimize the risk of care, but the environment in which care is now delivered causes, I think, the providers to set up all kinds of hedges to protect themselves against risks. And that costs something and it gets passed on.

While I don't want to argue that the cost of health care hasn't risen more rapidly than other costs. In many ways this rise is driven by the same things that are driving the rise in general costs. There may be some things that are about to happen that will start to put some counter pressures on that. But I can't be sure.

Senator BYRD. Well, your identification of the root causes—I don't dispute at all, but I don't see that any of the suggestions made attack any of those root causes. Maybe they do, but I don't see it offhand.

Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Mr. Chairman, I don't have any questions. Thank you.

The CHAIRMAN. Well, I want to thank both members of the panel. We appreciate this. We know there are some areas in there that we can focus on.

Mr. CARDWELL. We will be glad to consult if you want us to during your process. We will be glad to try to help.

The CHAIRMAN. Because we do have a short-term problem, and I didn't really see any long-term solutions. I mean if we reject all the long-term solutions and testify that we ought to have a long-term plan, and we don't want any short-term solutions, then I don't think we want anything. But I think you get a fairly good flavor from the members on this committee on both sides that something is going to happen. If you want to help us make it happen, you can. If not, we will do the best we can.

Mr. CARDWELL. We will like to try to help, sir.

The CHAIRMAN. Our next panel: Alex McMahon, again, who is no stranger to this committee. And Dr. James Mongan—we give him an extra half minute as a former staff member. Jim already has an aide so he is moving up.

Alex, I think you are first.

STATEMENT OF J. ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. McMAHON. Mr. Chairman and members of the committee you have my statement. I only want to make two major points.

I hope you won't indulge in any more tinkering with cost-based reimbursement, whether a 2 percent reduction of already accepted costs or some tinkering with section 223. That isn't the way to go because it doesn't provide incentives to reduce costs. You incur the cost and then you get 2 percent less. That has an encouragement in it to increase costs because the 2 percent is going to come off anyhow.

It seems to me that we have to address, and I am ready to address, Mr. Chairman, two major issues. One of them is the demand for care. I have talked to Senator Durenberger and others about that. I think consumer choice, getting the individual involved, injecting price consciousness, injecting a marketplace activity, is extremely important. I've been encouraging this on the part of business people.

It seems to me that that is the first thing. To do something about the demand for care. Now something is already happening. I'm a perfect example. I'm trying to deal now with a 60-percent rate increase from an insurance carrier. And we are going to do something about it. Senator Durenberger, whether in the short range it's an addition of some cost sharing or whether it's a development of a choice of plans, I don't know. But we are working on it. And we are talking about what has to be done.

And, secondly, we need a change in the payment system. Not cost-based reimbursement. We have been working with the Health Care Financing Administration and we have had some discussions with this committee on the issue of putting some incentives in. Let's get away from the cost-based idea that the more you spend, the more you get; the less you spend, the less you get. We have got to change that around. There are problems with it. There will be winners and losers in it. But it's the only way to go.

I received instructions the first part of this week from one of our councils to put a working party together to find out how we could do it, what the problems are, and to begin to proceed ahead. And we are ready to do so. We must change the incentives, Mr. Chairman and members of the committee. Government and business are insisting on it and it has to be done so that there are incentives to reduce costs, both on the part of the patients and the individuals who have family members, and on the part of the providers themselves. And it can be done.

I would like also to address, as I do in the last part of my testimony, an anticipated issue. You will have before you, Mr. Chairman, suggestions for limitations on the tax exempt bonds for not-for-profit hospitals. There is no reason to put any limitations on them I suggest, Mr. Chairman, because there hasn't been any abuse. And there are controls now with respect to hospitals, both through certificate of need at State level and because any tax exempt bond has to go through a public authority.

I have indicated on page 16 of the testimony, Mr. Chairman, that there has not been a large increase in capital expenditures financed by bonds. As a matter of fact, in real dollar terms they have fallen. In addition to that, if the access to tax exempt financing is denied I suggest it will be inflationary. It will be inflationary on two counts. The not-for-profit hospitals that can go into the market will go into the market and will pay more. And that will increase costs. Now not-for-profit hospitals that cannot do that are going to find the capital expenses then being made by other hospitals, both public hospitals and investor owned.

Now in any event, to deal only with the not-for-profit hospitals would be discriminatory and I suggest it is just going to increase the capital expenditure cost, not cut it back.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE COMMITTEE ON FINANCE
UNITED STATES SENATE
ON THE ADMINISTRATION'S BUDGET PROPOSALS
FOR FISCAL YEAR 1983

March 12, 1982

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association (AHA). The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members, is pleased to have this opportunity to present its views on President Reagan's Fiscal Year 1983 budget proposals as they would affect the programs under the jurisdiction of the Finance Committee.

It is important to note at the outset that my testimony today provides only a preliminary reaction to some of the Medicare, Medicaid and revenue proposals recommended by President Reagan for Fiscal Year 1983. Detailed comments must await release of the Administration's proposed legislation and a clearer statement of its regulatory initiatives. I hope the Committee will provide us with an opportunity to provide comments on actual legislative proposals before they are considered.

MEDICARE

Background

The FY 1983 Medicare proposals must first be considered in the context of a decade of attempts by four Administrations and six Congresses to restrain the growth in health care costs, and particularly in federal health outlays. These past efforts amounted to altering the existing reimbursement system to make narrowly-focused, short-range budget savings, while subjecting hospitals to ever-widening payment shortfalls and a heavy burden of regulation that has proved to be ineffective and counterproductive.

In part, the Administration's proposals for Medicare repeat these past failures, but there are also encouraging signs that the fundamental issue is being addressed of restructuring the entire payment system to provide effective incentives to providers and patients for restraining the rate of increase in health care costs.

We look forward to examining the details of the Administration's consumer choice/competition proposal, which we understand will be announced shortly. AHA has encouraged further consideration of consumer choice plans and we have provided advice and assistance to the Administration and to Congressional sponsors of such legislation.

AHA also is encouraging closer attention to the possibility of applying a prospective payment methodology to Medicare hospital services. We understand that the Administration is currently studying ways to implement prospective payment in Medicare, and AHA stands ready to provide whatever assistance is requested.

Hospitals, for their part, share the concern of the Administration and many in Congress over the continued rapid increase in the cost of providing hospital services, and the resultant pressure on the federal budget. In good faith, hospitals worked with government in implementing the Professional Standards Review Organization and health planning programs, which at one time appeared to hold the promise of effective cost restraints. Only when it became clear that these programs had become ineffective and therefore needlessly burdensome did hospitals call for their repeal. Hospitals also have worked among themselves to restrain costs, responding to a challenge in 1977 from the House Ways and Means Committee's chairman to establish, along with other groups in the health care industry, a program known as the Voluntary Effort (VE). As an interim program the VE worked, against considerable odds in a highly inflationary economy. Now we are actively promoting a new initiative in voluntary cost containment--locally-based coalitions of business, labor, insurers, providers and other interested parties working together to enable hospitals to restrain cost growth more effectively.

But despite hospitals' own efforts, despite reimbursement reductions and despite the now oft-repeated threats by some in Congress and government, hospitals continue to find themselves stalemated by the entangling web of conflicting pressures and expectations. Payments to hospitals for services are being restricted from virtually all sources, narrowing the options for shifting of shortfalls from one payer to others and jeopardizing some institutions' viability. Yet hospitals are expected to meet increasing demand for health care services under an insurance system, governmental and private, which by providing comprehensive health insurance encourages that demand to grow. The Committee should be reminded that federal and state law combine with community expectations to require that hospitals render care to those who ask for it. As long as those requirements remain, the financing system remains the only mechanism for controlling the growth in health care services without denying needed care. Therefore we must address ourselves to changing that mechanism in ways that will make it more cost effective.

With this background, I would like to comment on several of the budget proposals offered by the Reagan Administration as they relate to the Medicare program.

Disallow 2 Percent of Hospital Medicare Costs: The Reagan Administration proposes to reduce Medicare reimbursement to all hospitals by 2 percent. In addition, hospitals would be prohibited from billing beneficiaries for these unreimbursed costs. The Administration justifies this provision by saying that the proposal would affect all hospitals equally and would be administratively easy to implement.

AHA strongly opposes the 2 percent across-the-board reduction. This proposal neither recognizes the efficient hospital nor spreads the burden equally--two goals of this Administration. It actually would penalize those hospitals that have been most active in controlling Medicare costs. Under the proposal, no matter how cost efficient a hospital actually is, it would still be penalized 2 percent of its costs--2 percent below the already significant shortfall in payments hospitals experience for care rendered to Medicare patients.

The 2 percent disallowance also would severely penalize those hospitals with a high Medicare patient case load. It seems somewhat ironic that, under the Administration's budget proposal, the more committed a hospital is to serving the Medicare population the larger would be its financial shortfall in caring for Medicare patients. Regardless of patient mix, if the 2 percent reduction plan goes into effect, hospitals would be forced to try to shift their costs to other payers. Yet for many hospitals with high Medicare patient loads, which also are likely to have high Medicaid and medically indigent loads, there are few, if any, other patients who can absorb the shortfalls. This proposal could cause severe and irreparable harm to the financial integrity of these hospitals.

Apply the Hospital Insurance Portion of the Payroll (FICA) Tax to Federal Employee Wages: The Reagan Administration proposes that the Hospital Insurance portion of the FICA tax, which finances Part A of Medicare, be imposed on federal employees' wages beginning in calendar year 1983. AHA supports this proposal as an appropriate public policy decision. While most federal employees currently qualify for Medicare at age 65, they do not contribute commensurately to the Hospital Insurance fund. This proposal would provide equity in the current system and would significantly increase revenues to assure the financial stability of the Hospital Insurance fund.

Reimburse Radiologists and Pathologists at 80 Percent of Charges: While reserving judgment on this proposal, I must point out the impact which would result. The 20 percent coinsurance which would be instituted for these services would be borne by Medicare beneficiaries. For hospitals which have contractual agreements with medical specialists, the shortfall in reimbursement would necessitate that a hospital bill the patient in order to recover that portion which the hospital owes the specialist by contract. Congress instituted the 100 percent reimbursement and combined billing for these services in large measure to overcome complicated billing procedures which this proposal would reinstate.

Establish a Single Reimbursement Limit for Skilled Nursing Facilities and Home Health Agencies (SNF/HHA) Reimbursement: The Administration proposes to establish a single reimbursement limit on reasonable costs for hospital-based and freestanding skilled nursing facilities and a single limit for hospital-based and freestanding home health agencies.

AHA opposes this provision because it does not take into account the cost differences resulting from Medicare reimbursement rules on overhead charges and other associated costs. Further, it does not account for the more severely ill patients treated by hospitals and the complicated and intensive services hospitals provide. If Medicare should implement this proposal, the Medicare cost allocation rules must be changed to permit hospitals to allocate only the actual costs involved in providing these services.

Eliminate Waiver of Liability: This proposal would eliminate the waiver of liability afforded to an institutional provider when Medicare claims are disallowed because the care was deemed after the fact as not "medically necessary" or not a Medicare covered item, even when the provider is totally without fault.

The AHA believes there is no reason to penalize hospitals which have made efforts in good faith to provide needed services--services ordered by physicians and other professionals. There is no evidence that hospitals have abused this waiver authority. Repealing it would only increase existing bad debt problems, and force hospitals to take measures to assure that their services will be paid for--services which may prove to be uncovered through no fault of the patient or the hospital.

Change Medicare Contracting Initiative: There are virtually no details available regarding this element of the Administration's budget, except that savings in excess of $300 million are anticipated. One facet merits comment at this point--the proposal to terminate the providers' right to nominate the Medicare fiscal intermediary with which they will work. AHA continues to support the current arrangement, which has proved to be workable and which allows the Health Care Financing Administration to overturn the providers' nominations if they are unacceptable. Provider-intermediary relationships are crucial to the smooth operation of the Medicare program, with its myriad rules and procedures, and the constant flow of program changes which affect reimbursement. We are opposed to achieving savings through intermediary selection procedures which emphasize price as the primary criterion, because these savings would be more than offset by the disruption of the day-to-day operation of the Medicare program.

Expand Section 223 Limits: Although not included in the Administration's FY 1983 budget recommendations, expansion of controls under Section 223 (of P.L.92-603)* is under active preparation at HHS and we understand is being considered by some on this Committee. These new controls would apply to total Medicare hospital costs on a per admission basis with the possibility of some type of hospital case mix adjustment factor.

The AHA is quite alarmed over the possible extension of these limits to total costs. We view extension of Section 223 authority as merely a mechanism to deny hospitals reimbursement for the true cost of providing necessary care. The Department of Health and Human Services has had difficulty in developing an equitable and workable methodology for this type of regulation. Since we do not know the details of what HHS or this Committee is considering we take the opportunity today only to raise the issue and request further discussions with you.

Medicare Conclusion

Mr. Chairman, the Administration's FY 1983 Medicare proposals contain both encouraging and discouraging elements. To the extent these proposals move toward addressing fundamental questions of restructuring health care financing, AHA recommends further consideration and development. By contrast, those punitive measures which would repeat the same mistakes made in the past should be rejected and energy focused on more productive work.

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*Section 223 provides broad authority to the Department of Health and Human Services to impose limits on Medicare reimbursement to hospitals and some other providers.

We understand the budgetary pressures on Congress and the Administration and stand ready to participate in major reforms which will move toward solutions of those budgetary problems and reduction in the growth of health care expenditures. We cannot accept mere tinkering that imposes the wrong incentives on Medicare patients and providers. We look forward to working with you on fundamental change.

MEDICAID

Mr. Chairman, the AHA would now turn to those FY 1983 budget proposals affecting the Medicaid program. I would preface our remarks on specific aspects of those proposals by commenting that we have viewed with great interest the President's state-of-the-union comments suggesting a federal assumption of the Medicaid program. While there are many aspects of such a shift of program responsibility which we find worthy of additional discussion, we also recognize that that shift would render unnecessary several changes proposed in the FY 1983 budget. In the meantime, we will address proposed program changes as they would affect hospitals in the current environment.

Federal Match Reduction

Reducing the federal matching rate by 3 percent for optional services to the categorically eligible and for all services to the medically needy may well achieve short-run savings in FY 1983. But we fear that the long-term consequences of such an action will serve only to increase the nation's overall health care bill in future years. Reduction of the federal match at a time when states are themselves experiencing fiscal stress will inevitably result in a greater portion of the bill for services provided to the indigent being absorbed by hospitals as bad debts. Shifting the cost of such services to hospitals, particularly to public institutions and other hospitals with high Medicaid patient loads, would further damage these already financially distressed institutions.

We are concerned also that many of the health services provided in the optional category fall in the preventive category. As we all know, deferral of preventive treatment will in the long term result in greater expenditures on illnesses which might have been prevented. Especially in instances in which states such as New York and California provide a full range of discretionary services, we fear that excessive health care burdens will be shifted to state governments unable to meet those demands if the federal matching rate is reduced.

Copayments

AHA generally supports incentives for more responsible use of health care resources by beneficiaries. We question, however, whether nominal copayments for Medicaid services is the most appropriate way to achieve that goal. We fear that the Administration's proposal would only increase hospital bad debts. Hospitals will be reluctant to force collection of such small sums, especially since the Medicaid identification card does not distinguish between categorically and medically eligible beneficiaries.

Error Rate Reduction

We regard a phase-in full state responsibility for any erroneous payments under Medicaid as entirely inappropriate. Given a federal program as extensive and complex as Medicaid, and given the constant movement of individuals in and out of the program as their eligibility changes, it is unreasonable to expect states to achieve error-free administration.

Eligibility Extension

AHA also must oppose a reduction to one month in the automatic extension of Medicaid eligibility. The Committee should examine whether such a change would serve as a disincentive for some beneficiaries to seek full-time or more appropriate employment. In any event, Medicaid beneficiaries typically require a transitional period before private insurance benefits are provided. One month is simply insufficient for that transition. If the Committee does, however, feel some action is necessary in this area, AHA recommends two months, instead of the current four, as a more appropriate transitional period.

PSRO/UTILIZATION REVIEW

The Administration has proposed repeal of the Professional Standards Review Organization (PSRO) program in its FY 1983 budget. AHA fully endorses this proposal. The PSRO program has not been proven cost-effective nor has it measurably improved care standards. It has placed rigid federal demands on hospitals that have hindered adaptation to local needs. And the program has unsuccessfully tried to perform utilization review and quality assurance activities that are best performed at the local institutional level.

We do not believe utilization review and quality assurance activities will diminish if federal mandates are removed. The private sector, voluntary organizations, and local governments will initiate and fund these review activities where they believe they are needed. Well-functioning hospital patient care appraisal committees can ensure that care provided to patients is of high quality, appropriate duration, and is rendered in the appropriate setting without PSRO involvement.

The AHA House of Delegates resolution last year calling for repeal of the PSRO law also declared that PSRO repeal should be accompanied by concerted AHA action to assist member hospitals in upgrading their patient care appraisal capabilities where such deficiencies exist. AHA's program series, "Quality, Trending and Management for the 80s," is one example of ongoing efforts to assist hospitals in improving their quality assurance programs.

The AHA supports voluntary utilization review by hospitals. There are numerous incentives for hospitals to perform utilization review. The Joint Commission on Accreditation of Hospitals (JCAH), which accredits 5,000 institutions, requires both utilization review and quality assurance standards in its criteria for accreditation.

The AHA policy on utilization review calls for health care institutions to evaluate the medical necessity, appropriateness, and efficient use of health care services and facilities for all patients as a valuable mechanism for improving the cost-effectiveness of the health care delivery system.

Prior to enactment of the PSRO program, hospitals experienced problems with federally mandated utilization review. Among these problems were federal requirements for review committee composition, inconsistent review requirements for Medicare and Medicaid, and confidentiality of review data. A 1975 court action enjoined portions of the regulations, leaving the program requirements confusing and incomplete. New final regulations have not been issued.

In a recently released draft Intermediary Letter, HCFA has proposed that, in the absence of PSROs, Medicare fiscal intermediaries be allowed to perform medical reviews of inpatient hospital services in whatever manner they choose so long as federally determined "benefit savings targets" are met or exceeded. AHA believes that such an approach should not be tied to predetermined cost savings targets. HCFA proposes a system of fixed dollar-amount savings, which can only be labelled an arbitrary quota system. Such a system fails to recognize those hospitals already performing effective reviews and could result in unfair denial of payments to hospitals.

PSRO/Utilization Review Conclusion

The Administration proposal would ultimately set at odds those cost-efficiency and quality of care considerations that are inherent in the utilization review concept. AHA urges that medical qualifications of staff performing medical review for the fiscal intermediaries be comparable to the qualifications of staff performing that function in the institution, or a mutually agreed upon level of qualification.

TAX-EXEMPT BONDS

On the revenue side of the Administration's budget, one element of great concern to AHA is the Treasury Department's proposal to impose restrictions on the use of tax-exempt bonds by private, not-for-profit hospitals.

What we know of the proposal is derived from Secretary Regan's testimony before this Committee on February 23 and a detailed statement issued by the Treasury Department on February 26. As we understand it, actual legislation has not yet been transmitted to Congress.

Based on available information, AHA is strongly opposed to the application of these conditions to hospital use of tax-exempt bonds. It is inappropriate to impose yet another burden of proof that hospital projects are public purpose projects, and it is counterproductive to force hospitals to use more costly capital financing methods at a time when the federal government is trying to restrain health care cost growth, particularly in Medicare and Medicaid.

The Treasury Department's stated goals are to increase federal income tax revenues and reduce pressure on the municipal bond market. Under the proposal, these goals would be addressed by imposing a series of conditions ostensibly intended to assure that projects financed with tax-exempt bonds meet a public need. By including hospitals in its proposal, the Treasury Department reveals its shortsighted concentration on revenue enhancement, to the exclusion of another crucial public policy issue--health care costs. Moreover, the Department has revealed its ignorance of the existing heavy regulation of hospitals and their capital expenditures which ensure their public purposes. Finally, the Department misunderstands the role tax-exempt financing plays in hospital projects.

Tax-exempt financing is vitally important to minimizing the cost of hospital capital projects. From 1971 through 1981, the value of hospital bonds issued grew from $0.26 billion to $5.04 billion. In 1981, hospital bonds accounted for 11 percent of the total long-term, tax-exempt volume of $45.7 billion. In general, the interest rate for tax-exempt bonds is about 3 percentage points lower than comparable taxable obligations. During part of 1981, there was as much as a 30 percent differential between interest rates for tax-exempt and taxable bonds.

It is not true, as some have contended, that the growing use of tax-exempt financing by hospitals has contributed to a growth in capital expenditures. In fact, there is no demonstrated relationship. During the period 1973 through 1979, when the proportion of hospital construction financed with tax-exempt bonds rose from 21 percent to 49 percent, private hospital construction spending was relatively stable, rising from $3.05 billion in 1973 to $4.3 billion in 1979 (our most recent data). When inflation over that period is considered, the real value of hospital construction actually dropped to $2.6 billion in 1979.

Hospitals have turned to tax-exempt bonds to replace other sources of financing which have dried up, such as government programs and philanthropy. If tax-exempt financing is restricted, hospitals will turn to yet other sources, primarily the taxable market, which are more costly. The markets view nonprofit hospitals as a less desirable long-term risk, because of the increasing revenue shortfalls caused by government policies; thus, hospitals pay a premium in higher interest rates and shorter terms.

Under the Department's proposal, eight conditions would have to be met, in addition to those now in law, for the use of tax-exempt financing by nonpublic entities. Two of these conditions clearly are inappropriately applied to hospitals and would seriously impede access to tax-exempt financing:

--the requirement that each bond be specifically approved by an elected unit of government or by referendum; and

--the requirement that, after 1985, the unit of government issuing the bond contribute 1 percent of the project cost, either directly in cash, or indirectly by tax abatement, services provided, bond guarantee, etc.

Two other conditions are, at a minimum, sources of concern to hospitals:

--the requirement that all tax-exempt bonds be registered; and

--the limitation imposed on arbitrage income derived from short-term investment of bond proceeds.

Bond Approval

By requiring specific approval of each hospital-related bond by the highest elected official or body, or by referendum, this proposal would add another unnecessary and pointless requirement to the already closely regulated process of approving hospital capital projects.

With the existing combination of government oversight, can there be any doubt that an approved hospital capital project meets every conceivable local, state and federal government test of public purpose? This new approval is inappropriate because:

--by federal and state law, all sizeable projects are subjected to certificate-of-need review, which includes public hearings;

--in all states but one (Ohio), hospitals are licensed to operate;

--virtually all hospitals participate in Medicare and are therefore subjected to conditions of participation and certification;

--most hospitals undergo voluntary accreditation by an independent organization; and

--two-thirds of private, nonprofit hospitals received federal construction assistance under the Hill-Burton program.

Approval of bonds by elected bodies will only delay projects that already have been thoroughly reviewed and approved, thus adding to the expense of securing approval and adding to project costs, which in turn will be paid by the public who use the hospitals.

Financial Contribution

By requiring a substantial financial contribution from the unit of government issuing the bond, the Treasury Department's proposal effectively would restrict hospital tax-exempt financing to localities which can afford to contribute, and deny it in those areas where governments are under severe fiscal constraints, despite the demonstrated need for the hospital capital project. This federal rationing of tax-exempt financing would bear no valid relationship to "public purpose." Hospitals, whether public or private, are important community resources, with a significant--and sometimes exclusive--role, in meeting public health care needs. This is particularly true in rural and inner city areas in which financially strapped governments would be least able to meet the Treasury Department's contribution test.

For the elderly, poor, and unemployed in such a locality or state, denial of tax-exempt financing to the local private nonprofit hospital would increase health care costs. The proposal also would retard economic recovery and exacerbate the government's fiscal problems. For hospital projects, which all have a well-established public purpose, this requirement is inappropriate and counterproductive.

Bond Registration

While AHA does not disagree with the Department's goal of tracking sale of bonds for tax purposes, it must be pointed out that bond users (e.g., hospitals) commonly are required to pay any registration costs, which can be significant. The committee should consider whethere the value of registration outweighs the added costs to hospital capital projects.

Arbitrage Limit

Since the details of the proposal are not available, it is difficult to make a definitive comment. However, we must point out that Medicare currently imposes an arbitrage rule, which may make the Treasury Department's proposal duplicative, or even contradictory. We recommend that the Committee examine this aspect of the proposal in the light of current Medicare policy.

Tax-Exempt Bonds Conclusion

AHA recommends that the Treasury Department's proposed limits not be applied to hospital use of tax-exempt financing. At a minimum, the specific approval requirement and the financial contribution requirement must not be applied to nonprofit hospitals.

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STATEMENT OF DR. JAMES MONGAN, EXECUTIVE DIRECTOR OF TRUMAN MEDICAL CENTER, KANSAS CITY, MO., ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Dr. MONGAN. Mr. Chairman, I am Jim Mongan, executive director of Truman Medical Center in Kansas City, Mo. I'm here representing the National Association of Public Hospitals. And Larry Gage, the association's president, is accompanying me.

I appreciate the opportunity as a former staffer of this committee to return to this room, sit on the other side of the table, and bring you news from the front lines in the battle of the budget.

From my experience in Washington, I fully appreciate the budgetary issues you must wrestle with, and the hard decisions that must be made. We in the public hospital field must also make and are making hard decisions. We are caught in the deadly pincers between cuts in medicare and medicaid and an increase in the proportion of uninsured patients as a result of the worsening economy.

I'd like to do three quick things this morning: Give you some background on Truman Medical Center; flesh out our current financial plight, and give you our recommendations on medicare and medicaid cuts.

Mr. Chairman, for time's sake, I will pass over the important section in my prepared statement on how public hospitals are different, and move directly to a description of Truman Medical Center, the publicly supported hospital system for Kansas City, Mo.

We have about 500 beds. We employ just under 2,000 people, which makes us the twentieth largest employer in the Kansas City area. Mr. Chairman, a point I emphatically don't make in Jackson County, Mo., where they are sensitive about State lines, but whisper to you here is that 350 of those employees and their families are your constituents in the State of Kansas.

We provide care to over 10 percent of the population in Kansas City. I said public hospitals are different. Let me illustrate that by some specifics on our facility.

Public hospitals treat all patients who come to our doors. At Truman Medical Center over 50 percent of our patients have no coverage at all. Not medicare, not medicaid, and not private insurance.

Parenthetically, Mr. Chairman, I remember well discussions in this very chamber about national health insurance, and debates over how many people did or did not have health insurance coverage. For those members of the committee or the insurance industry who felt they were few and far between and very hard to find, I invite you to our facility to meet some of them.

Public hospitals provide a wide range of specialty services, which serve both rich and poor. We are the level one trauma center for Kansas City, Mo. This is expensive. Mr. Chairman, I saw very vividly what this service means to a community. The Hyatt Regency Hotel stands just two blocks from our hospital. On that terrible evening last summer when the skywalks collapsed, I learned the value of that center to the community. In the space of only a few hours, we had 23 of the most severely injured people—injuries beyond your imagination—brought to the emergency room. All but one of those survived. And in many cases, survived because we were there.

Public hospitals are financed differently than other hospitals. Our budget is $58.6 million. We receive 52 percent of our funds from third party payers, 10 percent from miscellaneous sources, and that leaves 38 percent of our budget which must be funded by local government as a funder of last resort.

During the current fiscal year, we've been faced with cuts in city aid of $250,000, and medicaid cuts of over $600,000. We've been able to absorb the bulk of these cuts through stringent cost control measures, including a cut of 80 employees at our downtown hospital.

Mr. Chairman, I've never seen a large institution that doesn't have fat. And we cut that fat. But I can recognize bone, and we began to get to bone in order to make the cuts we have made this year. We had to close an alcohol rehab unit. We had to reduce pharmacy services. We were close to having to cut the around-the-clock availability of nurses for the operating room and go to an oncall system.

The budget cuts will be harder next year. As a result of the cuts we made this year, our operating budget will increase only 9 percent next year compared to an area average of 19 percent. But the medicaid cuts will continue. Next year's will cost us an additional $1.6 million. That's half of the pincers that squeezes us. The other half is that we will see an increased proportion of indigent patients as the economy worsens, increasing our burden at a time of decreasing support.

We run a superb hospital, and provide medical care of the highest quality. We won't let it deteriorate. We have managed thus far through strong management and superb cooperation from local government to maintain those services. We will need help from you to continue to do so.

My first recommendation would be to avoid, if possible, further cuts in health spending this year. If you find you must cut further, I would have three recommendations. Stop cutting medicaid disproportionately. Please stop aiming at the patients and hospitals least able to cope and most in need. Mandate that the department enforce the provision in law that instructs States to give special consideration to public hospitals. And, finally, Mr. Chairman, I have a modest proposal: It's been only 2 years since I sat before this committee working with you on developing a national health plan, albeit a very conservative, limited plan. While others had talked of plans costing $100 billion or $30 billion, the Finance Committee, in its usual careful fashion was looking at plans costing $3 to $5 billion.

Economic and political tides change. And we are not talking this season about spending. Instead we are talking about cutting another $5 billion from medicare and medicaid. I know it has become a cliche, but we must leave the infrastructure or safety net intact. I'd ask you to consider a give back of a portion, say 10 percent of any savings you proposed in medicare and medicaid, to a program to support the local safety nets, the public hospitals, which will bear an increasing load as a direct result of the cuts. Attach any conditions of efficiency and cost containment you wish, scrutinize our budget line by line, but be a partner with the State, county, and city in keeping us intact in difficult times.

Thank you very much for the opportunity to be here. I'd be glad to address any broader questions during the question period.

[The prepared statement follows:]

TESTIMONY OF JAMES MONGAN, M.D., EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER, BEFORE THE SENATE COMMITTEE ON FINANCE, MARCH 12, 1982

Mr. Chairman, Members of the Committee, I am Dr. Jim Mongan, Executive Director of the Truman Medical Center, the public hospital system for the Kansas City, Missouri area. I am here today representing the National Association of Public Hopsitals, an organization representing 30 public hospital systems in our Nation's largest cities. I am accompanied this morning by Larry Gage, the Association's President, who is with me to answer any questions you may have about NAPH or its other members.

I appreciate the opportunity, as a former member of the professional staff of this Committee, to return to this room I know so well, sit on the other side of the table and bring you news from the "front lines" in the "battle of the budget."

From my experience in Washington over the past 10 years, I fully appreciate the cost and budgetary issues this Committee must wrestle with and the hard decisions which must often be made.

I believe I can also now speak for the "troops" in the public hospital field who recognize the hard decisions you must make, for as local governmental entities we must routinely make sensitive and difficult decisions ourselves. And it is precisely that shared sensitivity which impels me to caution you to make your current decisions with a view towards the special peril faced today by public hospitals and other hospitals serving the poor.

Such hospitals are caught today in deadly pincers -- between cuts, on the one hand, in Medicare, Medicaid and other public programs upon which we are disproportionately dependent -- and increases, on the other, in the proportion of indigent and uninsured patients as a result of the worsening economy.

I would like to accomplish three things in the brief time we have this morning:

- Give you a bit of background on public hospitals in general and our hospital in particular;
- Flesh out for you our current financial plight; and finally,
- Urge you to call a moratorium on further health cuts this year -- or at the very least, if you feel you must cut, that cuts be tailored to do the least possible damage to the fragile social safety net that public hospitals represent.

BACKGROUND ON PUBLIC HOSPITALS

Mr. Chairman, if I would leave you with one message about public hospitals it is that we are different.

- We take all patients who come to our doors, regardless of their ability to pay. We are the hospitals of last resort in our communities. This is in many ways our proudest mission - a mission in the best tradition of the healing arts - and yet at the same time, this is the root source of many of our special problems.
- We provide a broad range of expensive specialty services which serve the whole community, rich and poor alike, and which are often too costly for private hospitals to maintain. Such services include fully staffed and equipped 24-hour emergency services, shock trauma units, burn centers, poison control units, high risk pregnancy programs, drug abuse and alcoholism service and large outpatient clinics.
- In major urban areas, public hospitals represent just 1.6% of the hospitals, yet provide almost 25% of the outpatient clinic services.
- We are responsible for a great proportion of medical education in this country. Out of 7,000 hospitals

in the U.S., less than 100 public hospitals train over 40% of all post graduate physicians an dentists in internship and residency programs.

- We serve the sickest patients, ranging from high-risk pregnant teenagers, to the infirm aged poor (who often rely on both Medicare and Medicaid), to the victims of severe accidents and injuries. You find few patients in our hospitals with simple uncomplicated diagnoses.
- Finally, we are financed in a fashion very different than standard community hospitals. We tend to have high costs, as the special burdens we carry would indicate. Yet we receive little private insurance and a disproportionately small amount of Medicare money, and our budgets tend to inflate from year to year at far less than the national average. We are far more heavily dependent upon Medicaid than other hospitals, and most significantly, we are all dependent ultimately upon our local city and county governments for a large proportion of our support.

BACKGROUND ON TRUMAN MEDICAL CENTER

Mr. Chairman, Truman Medical Center is the publicly supported hospital system for Kansas City, Missouri. We have three facilities: a downtown 226-bed teaching hospital adjacent to the University of Missouri-Kansas City Medical School, a smaller 83-bed acute hospital in Eastern Jackson County, and a large 208-bed skilled nursing facilty adjacent to the smaller hospital.

We employ just under 2,000 people, which makes us the twentieth largest employer in the greater Kansas City area.

We admit over 15,000 people as inpatients each year, and there are over 180,000 visits to our outpatient clinics. We estimate that we are a major provider for over 10% of the population in Kansas City.

I just spent a few minutes emphasizing how public hospitals are different -- let me underscore that by some specifics from our facility.

- I said public hospitals treat all patients who come to our doors. At Truman Medical Center over 50% of our patients have no third party coverage at all -- not Medicare, not Medicaid, and not private insurance. Parenthetically, Mr. Chairman, I well remember discussions in this Committee about National Health Insurance and great debates over how many people had no health insurance coverage -- some claimed 15 million, some said 22 million, others 27 million. Whatever the aggregate number, it is a lot of people and most of them rely upon public hospitals for their care. To put it another way -- we are "national health insurance" in America today, where we are available to fill in that gap. For those members of the Committee or those in the insurance industry who thought that the uninsured were very few in number and hard to find, I invite you to our facility to meet them. The abstract discussion has fast become a reality for me.

o I said public hospitals provide a wide range of expensive specialty services which serve the whole community, rich and poor alike. Perhaps the most noted of these community-wide services at Truman Medical Center is our Emergency Service. We are the Level I Trauma Center for Kansas City, Missouri. This is expensive. It means our Emergency Department, Operating Rooms and back-up services are fully staffed and equipped around the clock -- prepared for the most major sort of trauma. Mr. Chairman, I had been in my new position for 2 weeks last summer when I saw vividly what this service means to a community. The Hyatt Regency Hotel stands two blocks from our hospital. On that terrible evening last summer when the skywalks collapsed, I learned the value of a trauma center to a community. In the space of only a few hours we had 23 of the most severely injured people -- some with injuries beyond your imagination -- brought to the emergency room. All but one of those survived, and in many cases survived because we were there. I hope for the community's sake that that level of service can be maintained.

o I said public hospitals are financed differently than standard community hospitals. An average hospital may receive some 60% of its revenue from private insurance, some 35% from Medicare, leaving 5% to be funded from Medicaid or out-of-pocket payments, or to be written off as bad debts or "charity care."

Our operating budget at Truman Medical Center is $58.6 million. Like other public hospitals, we receive about 20% of our funds from Medicare, 20% from Medicaid, 12% from private insurance and private pay, and 10% from grants and University money. This leaves about 30% of our budget which must be funded by Jackson County and Kansas City. They are the funders of last resort.

CURRENT FINANCIAL PLIGHT

Mr. Chairman, against that background let me describe how we have dealt with last year's cuts and what we face in the year ahead.

Truman Medical Center had been quite a financial success story in recent years. Through increased operating efficiencies and improvements in billing and collecting from available third party payors, we had slowly decreased our dependency on City and County government in terms of the proportion of our budget which they fund.

During the current fiscal year we have been faced with two serious cuts in our revenue sources. The City, which has had its own financial problems due to economic conditions and cuts in Federal aid, has cut $250,000 from their payments to us. More seriously, State Medicaid reductions, which flow in part from the cutback in Federal payments, have amounted to over $600,000 thus far in this current budget year. This $600,000 reduction in payments flows primarily from three State Medicaid changes: a ceiling on per diem payments, arbitrary length of stay limitations which do not take into account complex cases, and cuts in general relief coverage for indigent patients. Please note that not one of these changes has resulted in a reduction in the demand or need for our services -- only in the payment we receive.

We have been able to cope with and absorb the bulk of the cuts this year through very stringent cost control measures of our own. The most severe of these was a cut of 80 FTE employees at our downtown hospital -- a cut equivalent to about 8% of our non-nursing personnel.

Mr. Chairman, I have never seen a large institution without some fat in it, and we cut that fat. But I can recognize bone and we began to get to bone in order to make the cuts we've made thus far this year. We had to close an alcohol and drug abuse rehabilitation program. We have had to reduce some services in our pharmacy. We were getting close to having to cut the round-the-clock availability of nurses for the operating room and go to an on-call system with a concomitant decrease in response time.

As has been your experience in Washington, mine in Kansas City has been that the cuts will be a great deal harder next year.

But let's look at next year. As a result of the cuts we have made this year, our operating budget will increase only 9% next year, compared to an area average of 19% for hospital costs. The County and the City have both treated us very fairly and have allocated close to what we requested to maintain this lean budget.

But the Medicaid cuts will continue. The annualized impact of this year's Medicaid cuts would be $1.2 million dollars. These cuts will result from the 3% cut in Federal matching for 1982. To deal with the 4% cut already scheduled for next year the State will presumably need to make cuts in our budget with an annualized impact of $1.6 million.

Yet all this is only half of the pincers that squeeze us. The other half of the squeeze is the increased proportion of indigent patients we continue to get as the economy worsens -- substantially increasing our fiscal burden at a time of decreased support. In short, we feel we could be in great peril indeed -- even without the further reductions proposed by the Administration this year.

Mr. Chairman, we run a superb hospital and provide medical care of the highest quality. We will not let it deteriorate. We have managed thus far through strong management and outstanding cooperation from local government to maintain our high quality services. We will need help from our Federal and State partners if we are to continue to do so.

RECOMMENDATIONS

My first recommendation would be to avoid, if possible, further cuts in health spending this year. We are still coping with the impact of cuts mandated thus far -- and some of that impact has not yet been felt. To move further without fully appreciating that impact could be devastating to the national health.

If you find you must cut further this year, there are a few recommendations I would make:

- o Stop cutting Medicaid disproportionately. Although this year's proposed budget calls for a larger absolute cut in Medicare than in Medicaid, it represents a steeper percentage cut in Medicaid. Don't assume States will simply absorb reduced matching rates for certain services or beneficiaries. At best, they pass it on through arbitrary reductions in payments. At worst, people lose eligibility altogether --

and the City or County becomes wholly responsible for their care. Please stop aiming your cuts at the patients and hospitals least able to cope and most in need.

- Mandate that the Department clarify and vigorously enforce the provision in last year's Reconciliation Act that instructs the State to give special consideration to those hospitals which serve disproportionate numbers of low income patients. If necessary, NAPH will work with you to write into the Social Security Act a clearer definition of those hospitals which for better or worse already serve as your nation's institutional safety net, and to develop ways you can be more sensitive to our needs.

- Finally - I have a modest proposal. It's been only two years since I sat before this Committee working with you on developing a National Health Plan - albeit a conservative, very limited national health plan. While others had talked of plans costing $100 billion dollars or $30 billion dollars, the Finance Committee, in its careful fashion, was looking at plans costing three to five billion dollars.

Economics and political tides change and we are not this season talking about new spending. Rather, you are talking about cutting sums of that magnitude from Medicare and Medicaid. But if you find you must do so, you may want to consider doing so in a way that leaves our health system's infra-structure or safety net intact as we go through these difficult times. For that reason, I would ask you to consider taking a proportion of what ever you feel you must cut -- say 10% of any Medicare and Medicaid savings you may wish to propose -- and set it aside in a trust fund or some other program designed to provide institutional support for that local safety net -- the public hospitals and others which serve a disproportionate number of the poor.

Such a proposal may at least protect the vulnerable institutions which will bear the heaviest load as a direct result of your cuts. Attach any condition of efficiency or cost containment you wish -- scrutinize our budget line by line -- but be a partner with the State, County and City in keeping the foundation of our health care system intact through difficult times.

Thank you.

The CHAIRMAN. Well, thank you very much. I just have a couple of questions. I think you are right. I think last year medicaid—this year is going to increase only about 6 percent; medicare about 17 percent based on what happened last year. So I think that point is well taken. And medicare, at this point, does appear to be the bigger problem.

There has been a lot of discussion in Congress that Congress place some sort of limits of medicare revenues to hospitals in a fashion similar to President Carter's proposals on all hospitals; the one you are familiar with. Do you think that has more merit now than it did when you were trying to sell it? Not sell it, I mean encourage it.

Dr. MONGAN. Mr. Chairman, I may blow any opportunity I have for office in the American Hospital Association by too much direct comment on that. I guess, basically, I believe that the major elements of that proposal were sound. There were flaws in the proposal. I would like to see, and I think AHA agrees with this, a strong State role. I guess I do believe that whether you call it prospective rate setting or you call it the nasty word of a "ceiling," I do believe that's the only answer to dealing with the cost.

Mr. MCMAHON. But, Mr. Chairman, they are different. I object to a ceiling, a ceiling that just deals with cost has no incentive in it. There may be an incentive to get under the ceiling, but then it applies only to those over the ceiling. When you establish a ceiling instead of something that has an incentive in it, you will find it is the incentive that is going to bring about some changes. And if controls apply to only one or two programs, there is just going to be a cost shift of any costs that exceed the cap.

The CHAIRMAN. Whatever happened to that voluntary program that hospitals touted so highly? I mean cost went up 19.6 percent last year.

Mr. MCMAHON. You are right that costs were up sharply last year—the figure is 18.7 percent for 1981.

The CHAIRMAN. Many of us voted against the Carter mandatory plan because we were told positively that this voluntary effort—if it is undertaken, you don't need it.

Mr. MCMAHON. And it worked splendidly for 2 years. It has not worked in the last couple of years because the voluntary effort was up against all of the incentives that are inherent in cost based reimbursement, and all of the incentives in broad comprehensive health insurance.

The CHAIRMAN. What do we do now?

Mr. MCMAHON. The two things I suggested. Let's get about figuring out a way to bring a cost consciousness into the mind of the individuals who place the demands on the system. By some kind of consumer choice or a cap on the amount of the health insurance that is protected by the tax laws. And, second, get about a prospective payment system that will not only set a limit, but that will leave something to the institution who can beat the limit. That's when the incentives in this system will change.

The CHAIRMAN. Right. And we are looking at all three of those, I might add.

Mr. MCMAHON. Right.

The CHAIRMAN. And I think prospective reimbursement, as I understand it, since it has been finally put together does make a great deal of sense if there is some incentive.

Mr. MCMAHON. Right.

The CHAIRMAN. You know, to do better, and to keep any balance, certainly, that's the incentive that I think Senator Long and others have talked about for some time.

Mr. MCMAHON. When you get to it, I hope you will call it prospective payment, because prospective reimbursement is a contradiction in terms.

The CHAIRMAN. That's true. That wouldn't be unusual around here. [Laughter.]

Not in this committee, but in others.

Mr. MCMAHON. I wanted to keep you from another error.

The CHAIRMAN. Right. We don't mind making a few errors, but we apparently made a lot of them because the cost of medicare is just going out of the ceiling.

Mr. MCMAHON. Absolutely.

The CHAIRMAN. Now, can you help us get $2 or $3 billion in fiscal 1983?

Mr. MCMAHON. Yes; if that's what you want. Because, depending on what you want—if you put a limit that comes close to it and then do not question the institutions that stay under the limit, you would come closer. But if it's 2 percent across the board, I suggest, Mr. Chairman, that isn't the way to go.

The CHAIRMAN. I agree with Senator Long and others. I don't really believe we gain much with the 2-percent solution.

Mr. MCMAHON. Yes.

The CHAIRMAN. But we do have the problem. You both understand that.

Mr. MCMAHON. Absolutely.

The CHAIRMAN. You've been here many, many times. Not that anybody likes to reduce the cost—well, I guess maybe we should reduce the cost of programs. If we don't, the impact on low income—that gets back to the medicaid area primarily.

Do you think we ought to federalize medicaid, Jim? Do you like the New Federalism? The Governors like to give us medicaid, but we haven't found anything yet they want.

Dr. MONGAN. I was pleased to see President Reagan put forth a proposal that I read as an endorsement of the Long-Ribicoff-Carter health insurance discussion which calls for federalized medicaid, along with catastrophic. And he has got half of it right.

The CHAIRMAN. So you would support that?

Dr. MONGAN. Compared with Missouri's program, I would support a federalized medicaid.

The CHAIRMAN. Alex, do you have any comments?

Mr. MCMAHON. I think so, too. There are problems that we have to look at. And even in the suggestions they are making to you, Mr. Chairman, I know Jim would raise a caveat about the public hospitals because they are in a more vulnerable position—even in a target rate situation—than some of the voluntary institutions. And attention has to be given to that. But the federalization of medicaid—if you can accommodate it, makes great sense. We are waiting to see the proposals as to what are the eligibility criteria, national or local, or how they are going to work.

The **Chairman**. Well, some of the Governors testified yesterday indicating it doesn't make much sense to cut back medicaid for fiscal 1983 if we are going to assume the whole program. They didn't believe that we should make additional cuts, even though there may be some areas we could make additional cuts in. And I assume that's a view you express in your statement. And I might say that your entire statement and other statements will be made a part of the record in full although you have summarized them. Senator Durenberger.

Senator **Durenberger**. In light of the unique nature of public hospitals, I am a little surprised at the answer to the question of federalizing medicaid. You didn't have time, of course, to discuss problems concerning the cost of teaching, researching, and other issues which must be faced by public hospitals in this country.

Both of you have spoken of a stronger State role in containing costs. Obviously, public hospitals have an essential State and local role in caring for the indigent. I'm concerned at the 50-percent figure, and I imagine that is increasing rather than decreasing.

I'm pleased with the way you poll the needy and the elderly separately. Their needs are indeed different. I heard Alex refer to a certificate of need as a justification for not looking at tax-exempt bond financing. The certificate of need is a Federal invention that largely has been discredited and we seem ready to phase it out. Franchising may be OK for Wendy's and McDonald's, but it's not OK for Government. Certificate of need franchises some health care facilities and stifles competition.

Having said all of that, how in the world do you federalize medicaid? If you federalize medicaid, you run the same risks as other Federal programs. When budget pressures demand it, we cut back on reimbursement. In medicaid, we are already going after the optionals. Wouldn't it just be worse if the whole program was Federal? What's the value in federalizing the needs based part of this system? How do we go about doing it? You don't wait for the administration to give you the answers. Don't wait for Congress to give you the answers. You are the people that are dealing with it every day. How would you do it?

Dr. **Mongan**. Mr. Chairman, obviously, my facility has a self-interest in federalized medicaid. I'm assuming a federalized medicaid would include some minimum floor of benefits in eligibility. The condition of Missouri's is a very thin, medicaid program. So, I am going under the assumption that the Truman Medical Center can only benefit from a federalized medicaid with some higher floor than Missouri's. I may find I am kidding myself, but that's the first assumption.

I agree that a federalized medicaid program itself again changes the payer only. You still have to deal with the cost issue. I am in agreement, and Alex is correct to point out the importance the incentives make. I believe we must develop a prospectively set rate with some incentive for those who fall below the minimum level. That has got to be made part two, it seems to me, of any federalized medicaid proposal. And it is the part which should probably be passed first.

Senator **Durenberger**. Alex?

Mr. **McMahon**. I think that's the key. It's the lack of uniformity that exists today. A lack of unformity in eligibility and benefits and in payment mechanisms. And with that mishmash out there in equitable dealings both with individuals and with providers in different parts of the country, I think it deserves a careful look.

Senator **Durenberger**. It is my understanding that assigning a dollar amount to a medicare voucher or perspective reimbursement payment is not difficult because we can deal in terms of age, sex, previous health conditions, and community cost. But I am told we have a substantial problem when we try to apply prospective reimbursement to the needy because of eligibility status and differences in age, sex, and family size.

How do you apply your recommendations for prospective reimbursement to medicaid or to the needy part of this system?

Mr. **McMahon**. I think prospective payment, Senator, applies to whatever you are doing. You set a price in advance to the provider and then it is up to the hospitals and the medical staff of the hospitals to work out the care of a group of people within the money that is available. It raises the issue, then, of making some choices about what it is you are going to do. It doesn't deal with the individual. It's the hospital and the medical staff, the physicians, then that have to deal with the individuals within the amount of money that is set aside in advance. It does not involve the individual. That's why I made the distinction between the impact on the demand side of consumer choice or that approach. That's the way you get to the individual—the patient. Prospective payment is that which incentivizes the hospitals and the physicians to deal with a group of sick and injured patients within the construct of a certain amount of money. What happens is what Jim described earlier. Then you have to drop some things that maybe have a lower priority than others.

Dr. **Mongan**. If I could just add one quick point. I don't equate a prospectively set rate with a voucher system in my own mind. I mean they are two separate issues. And, as you've discussed, I believe you do have the problems with the voucher system with respect to the poor and needy population. It is a constantly churning pool of people.

Mr. **McMahon**. I agree.

The **Chairman**. Senator Long.

Senator **Long**. You are fairly familiar, I believe, with my views toward putting people to work rather than just paying people for doing nothing. And I am sure you are aware of the fact that we have worked out a program here where the people can be hired in day care centers; work there. And they were welfare clients and they were hired into the day care centers. Either directly or indirectly we find ways to pay 100 percent of the cost. And there is a good argument for that. It is better having those people doing something useful with their lives rather than have them just sitting there making no contribution.

Now, in your kind of hospital, I wouldn't be surprised to find that you might be running a day care operation in connection with the hospital to look after the children while the mothers are working in the hospital. Do you do something like that?

Dr. MONGAN. Mr. Chairman, I wish we did, but that was one of the activities that we were unable to conduct due to a lack of funds and facilities.

Senator LONG. Well, I happen to believe that we should not be paying money other than just an initial grant of 1 month's check to a proposed welfare client to hold hide and hair together long enough for them to arrive at some job. And we ought to assume the burden of providing employment opportunities.

Now, if we would simply take what it would cost to put some of these people to work and just arrange that the welfare agency was to pay the money directly over to the hospital, and the hospital would pay them to do work, I think that that would be far superior to this working experience program because we are not projecting the image there of requiring people to work after the fact. We are not playing Indian giver. You are paying them to do actual work.

And you have heard the various discussions around this committee staff, do you think there is a potential there to reduce what we pay people for doing nothing and paying a lot of these people to do some work and helping to do the essential work that must be done around the hospital?

Dr. MONGAN. Senator Long, I think there is potential. In fact, our hospital has participated in programs of that sort. We've had CETA employees; we have had WIN employees in the hospital. We do not at the present time. Both of those programs were cut in that area. Missouri has recently passed a new proposal of that sort; they have discussed placement possibilities with us and we have agreed to use some of those workers. I'm generally supportive of doing some of those things. There are obvious pitfalls. There are some added costs in terms of training. There are some problems with a person who just wants to drop every third dish or something of that sort. But I think in general it is an approach that makes sense.

And, again, in a hospital of our sort, we use as many community people as we can.

Senator LONG. Well, I'm familiar with the fact that in the case of families—let's say young people with children. The young people are working or they are sufficiently affluent to where they can hire somebody to look after the children, so mama and daddy can go out once in a while and that type of thing. They have more choice about what they do with their activities. Civic work or whatever. The people that are available to them to be hired to look after children while those people go out and do something, be it work or whatever. A lot of those people are on those roles as being disabled, but if you pay them enough, they can do a pretty good job of looking after children. And some are on the welfare roles. But oftentimes what they want is for those people not to report the income. That's not right. We would rather pay them to work than to do nothing.

But there are a great number of people on those roles who can do some useful work. And my thought is that rather than paying those people for doing absolutely nothing, we ought to be paying the money to a hospital—as one example. Hospitals and day care centers are two of the most obvious cases that occur to me where we can put people to work doing something that they are capable of doing. They might not know how to do some highly technical work, but they know how to mop a floor, and they know how to sweep a floor, and they know how to pick up litter. And they know how to wash linen. Much of the kind of work that has to be done around a hospital. I'm just asking you if there isn't a potential for paying a lot of this money to the hospitals as well as day care centers to put these people to work?

Dr. MONGAN. I think there is. In fact, we have tried to go even beyond that and have some excellent summer training programs to try upgrading people into more advanced jobs. And that has been relatively successful over the past few years. So, again, I am generally sympathetic.

Senator LONG. Mr. McMahon.

Mr. McMAHON. It would not only apply to the public hospitals, Senator Long. As you know, it would apply to many of the not for profits. Even the investor-owned hospitals would be interested in a participative role in a program of that kind.

Senator LONG. If I had to pick, what is the greatest waste in Government, it would be all that money we are paying out to pay people to do the wrong kind of thing. You can't say you are just paying them to do nothing when you hand that money out because oftentimes those people, if you weren't paying them to just sit there and think up mischief that they could get into or to be idle or vegetate as the case may be—those people by just the compulsion of economic circumstances would be out looking for an opportunity to work. And there's a lot of work out there. But if we would pay for the work, then they wouldn't have to be sitting there doing nothing. And if I had to think what is the most counterproductive thing I know of in all the activities, it's all this money we are paying out for able-bodied people to do nothing.

And while I am talking about that, I would include the generality that a lot of this money that is going into the unemployment insurance. It's one thing to pay some fellow something to hold him until he can get a job somewhere else. But you take these people who, every year, are back for that. Especially when hunting season opens in Louisiana, there they are back showing up for that. When deer hunting season opens, it looks like they have all been laid off all of a sudden. They want to be on that unemployment up until the deer hunting season is over. So they are not available to work, but they are available to go draw that money down while they hunt the deer. Even in that case, where people do the same thing all over again, they should not be an insurable risk. We ought to say, look, we will pay the money if you do something. And provide some alternative jobs for you but we just are not going to pay you to do absolutely nothing. That's where I think the great waste in Government is. And I think it must be about $20 billion a year. If you add it all up. What we are paying people for doing nothing when we could be paying them to do something useful.

Now a hospital like yours, I'm sure is a fine hospital. I hope to come visit when I am in Kansas City. You have visited our charity hospital at New Orleans.

Dr. MONGAN. Yes, I have.

Senator LONG. When I go around there, I look at all these people, all these poor souls, that show up with their children in arms and all that at the charity hospital wanting some help and some service. And I am all for paying for it. I have been to that hospital many times. But all those people there on the taken down end looking for service, most of them are living on welfare. And I find myself, and I find myself saying why can't they be on the putting up end to help do some of the work that has to be done to provide the services in that big hospital down there. And I am not angry about it or anything. I just think we do those people a disservice to pay them to be idle. We ought to pay them to do something useful. And if need be, as you suggested, train them to do something even more useful. There is where I think we are wasting our money. And then to come in here cutting back on the actual care of sick people while we are still pouring that money out.

Mr. **McMahon**. We agree.

Senator **Durenberger**. Thank you, very much, gentlemen. Our next witness is Dr. Thomas G. Bell, executive vice president of the American Health Care Association, Washington, D.C.

Mr. **Hermelin**. Senator, Dr. Bell was taken ill and I am going to be substituting for him.

STATEMENT OF WILLIAM M. HERMELIN, DIRECTOR OF GOVERNMENT AFFAIRS FOR THE AMERICAN HEALTH CARE ASSOCIATION

Mr. **Hermelin**. My name is Bill Hermelin. I am the director of government affairs for the American Health Care Association. And with me is Gary Capistrant, our director of congressional relations and public policy.

The American Health Care Association is the Nation's largest organization of long-term health facilities with nearly 8,000 proprietary and nonproprietary facilities, and serving 750,000 convalescent and chronically ill of all ages. And we are pleased to present our recommendations for the fiscal year 1983 medicare and medicaid budgets.

Our written testimony focuses on several very specific opportunities for instituting cost effective medicaid and medicare long-term care policies. And I ask that it be incorporated in the record.

The **Chairman**. Without objection, it will be.

[The prepared statement follows:]

STATEMENT BY DR. THOMAS G. BELL, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr Chairman and Members of the Committee:

The American Health Care Association, the nation's largest organization of long term care facilities with nearly 8,000 proprietary and non-proprietary facilities which serve 750,000 convalescent and chronically ill of all ages, is pleased to present our recommendations for Fiscal Year 1983 Medicare and Medicaid budgets and some long term care related matters. I am Dr. Thomas G. Bell, AHCA Executive Vice President, and with me is Gary F. Capistrant, our Director of Congressional Relations and Public Policy.

First, I want to indicate our appreciation for the efforts of this Committee last year to draft a set of reasonable and responsible reforms for Medicaid and Medicare in light of the budget directives. The 1981 Medicaid and Medicare package minimized the adverse impact of significant budget reductions on recipients, services, and providers. There is recognition of your interest to institute policies which encourage more efficient and effective provision of health services to the elderly and poor.

I will focus on other opportunities for instituting cost-effective Medicaid and Medicare long term care policies. AHCA urges the Committee to reject proposals which merely shift federal costs to others or which have severe impacts on certain types of recipients, services or providers. With the Administration's commitment to soon bring forth two fundamental changes in federal health care involvement -- a competitive health program and federalization of Medicaid -- it is particularly an inappropriate time to consider disparate and potentially counterproductive spending cuts.

If the Congress insists on deep cuts in these two programs, we suggest that there is greater opportunity to achieve savings in Medicare. It is our experience that most state Medicaid programs have been much more aggressive and innovative in cost containment, using such things as prospective payment methods, competitive bidding for services and medical items, group health plan enrollment and utilization safeguards on heavy users of services. Furthermore, it should be noted that such state efforts will continue because of state budget problems independent of any further federal actions.

Prospective Payment System for Medicare SNFs

AHCA recommends that the Medicare program can achieve significant savings and enable beneficiaries to receive the appropriate services in the least costly setting by implementing a prospective reimbursement system for skilled nursing facilities (SNFs). The prospective payment system must include incentives for efficiency and cost containment.

There is a serious problem with the lack of participation by long term care facilities in the Medicare program. As a result, many Medicare beneficiaries in need of SNF care are not able to receive the appropriate care and are "backed-up" in expensive hospitals longer than necessary awaiting SNF placement. Medicare's inappropriate payment system is the major reason for the lack of participation by SNFs in Medicare. If Medicare adopted a prospective payment system more SNFs would participate,

beneficiaries would be able to receive needed SNF care more promptly, and the Medicare program would achieve long run savings by paying for SNF care in lieu of hospital care and by providing incentives for efficiency and cost containment. An independent study funded by AHCA, "Medicare and the Nursing Home Patient: The High Cost of the Shortage of Medicare-Certified Skilled Nursing Home Beds", which elaborates on many of the points we will raise and is available to the Comittee.

At any given time there are 19,000 Medicare beneficiaries "backed-up" waiting for a SNF bed and Medicare dollars are being wasted. A national survey undertaken in 1980 by the American Association of Professional Standards Review Organizations indicated that Medicare was paying for more than 6 million days of hospital care per year for patients for whom a bed in an SNF could not be found. A recent study by the Urban Institute confirms these estimates. The study found that because of the limited access to nursing home beds, Medicare and Medicaid pay for an estimated 1 to 9.2 million hospital days per year for patients unable to find a nursing home bed.

Last year the House Select Committe on Aging reported that "cutbacks in the Medicare nursing home program have resulted in keeping thousands of older Americans in hospitals longer than necessary at four times the average daily cost." The Committee estimated that "retaining patients in hospitals longer than necessary is costing Medicare and the nation $1.5 billion a year."

Before addressing the prospective payment system it is first helpful to review some relevant facts and developments concerning Medicare and nursing homes. Nursing home services are a small component of Medicare. Less than two percent of Medicare cost is for nursing homes. Similarly, Medicare accounts for only a very small proportion, approximately two percent, of total payments for nursing homes. National nursing home costs are primarily paid by Medicaid (50 percent) and personal resources/family support (42 percent).

The nursing home component of Medicare has been steadily decreasing both in terms of covered days (per thousand enrollees) and in the growth in nursing home expenditures as compared to hospital expenditures. Nursing home days per thousand enrollees dropped over 17 percent just between 1977 and 1979.

Approximately one-third of the SNFs choose not to participate in the Medicare program, and many who are certified for Medicare choose not to take Medicare beneficiaries if other patients are availble. In 1980, Congress was concerned about the inadequate access of Medicare patients to SNFs and instructed HCFA to study the causes and the extent to which laws and regulations discourage Medicare participation. In response, HCFA funded a study by the Urban Institute which was recently completed-

"Medicare and Medicaid Patients' Access to Skilled Nursing Facilities. The HCFA report was due in December, 1981.

The Urban Institute study supports the finding that Medicare patients do not have adequate access to SNF beds because of providers' reluctance to participate in the program and/or admit Medicare patients.

Some of the findings and conclusions of the study are:

- Medicare and Medicaid patients have problems obtaining the nursing home care to which they are entitled.
- Because of limited access to beds, Medicare and Medicaid pay for an estimated 1 - 9.2 million hospital days per year, for patients unable to find a nursing home bed.
- One-third of the skilled nursing facities participating in Medicaid do not participate in Medicare.
- Participating homes may avoid billing Medicare - instead billing patients directly or billing Medicaid - where Medicare coverage is uncertain or difficult to acquire.
- Greater uniformity in administration of Medicare's nursing home benefit would assure Medicare beneficiaries more equal access to the coverage the law provides.
- If Medicare used a prospective payment system, more homes would participate in Medicare, increasing the number of beds available to Medicare patients.

The eroding nursing home benefit under Medicare must be restored from the perspective of both the beneficiary and the program. Medicare beneficiaries are entitled to SNF care and believe they will receive this care. However, because the program does not provide sufficient access to nursing homes many beneficiaries are forced to go without the care they need or are forced to remain in hospitals. When beneficiaries remain backed-up in hospitals they are not receiving the appropriate care needed. A hospital does not provide many of the services such as activity services and group dining services that are appropriate for patients in need of SNF care. Thus, a patient is maintained in an inappropriate, more confined setting than would be best for the patient's needs. It should be noted that an increase in Medicare participation of nursing homes is not an expansion of benefits but rather an increase in beneficiary's access to existing benefits.

From the program's perspective, increasing beneficiary access to nursing homes will reduce the back-up of patients in hospitals and enable the program to pay for less costly SNF care. Although Congress recently enacted provisions which reduce payments to some hospitals for patients in need of SNF care, the mechanics and nature of the Medicare payment system for hospitals are such that significant savings will not result from that approach. This is confirmed by the Urban Institute study.

The SNF benefits were intended by Congress to be a substitute for more costly hospital care in the course of treating an acute illness. However, the result of limited nursing home services and existing inappropriate policies has been to reduce the elderly's access to covered care and to escalate Medicare expenditures for unnecessary and costly hospital stays. Medicare is "penny wise, dollar foolish" in the coverage and accessibility of post-hospital extended care services.

The major reason for the low participation is the Medicare reimbursement system. The current retrospective reimbursement system is unsatisfactory because it is inflationary, contains no incentives for efficiency, and no financial incentives for SNFs to participate. A reimbursement method that allows nursing homes simply to pass costs through the system without providing them with any real incentive to cut those costs must be considered inflationary. Much of the dramatic increase in costs for all health services over the last ten years can be attributed to the use of retrospective cost reimbursement. When costs are retrospectively determined, nursing homes cannot determine at any moment what they will reimbursed and hence link the level of care being provided with the reimbursement they will receive. Under such conditions, setting budgets and monitoring performance is difficult. A nursing home that contains costs and increases efficiency is penalized by having its reimburement level reduced by the size of the saving. Cost reductions only reduce income.

The use of a prospective payment system for nursing homes is not a new, untried idea. The virtues of prospective reimbursement are known. Over two-thirds of the State Medicaid programs have successfully employed prospective payment systems for nursing homes for several years. The experience of states is that prospective reimbursement has proven to reduce the growth in costs because of provider advantages to more efficient performances. One study (Robert Buchanan; California State College) found that between 1976 and 1977, Medicaid SNF payments increased 29 percent less in states that had prospective rate setting programs.

Prospective payment rates will instill market forces into the system. Providers would not have to deal with retroactive recoveries but would inherit the risks and the returns of receiving a prospective rate. Once the facility's rate is determined the provider would provide services for that rate and would incur a loss if its costs were too high or would receive a profit if its costs would be kept lower than the rate.

Congress and the Administration have continually indicated that Medicare should adopt a prosepctive payment system. Additionally, the White House Conference on Aging recently recommended that a prospective reimbursement system be used under Medicare. The need, advantages and support for prospective payment rates are clearly evident.

Applying a Medicare prospective payment mechanism to nursing homes prior to its application to hospitals would provide valuable experience to the program and Congress. Since the expenditures for the SNF component under Medicare are minimal compared to the hospital component, the financial risk to Medicare and skilled nursing providers in making a change is much less than for hospitals.

The next aspect we will address are some of the specifics of establishing a prospective payment system. The system must result in prospective rates that contain incentives for efficiency, provide for the adequate reimbursement of property costs, and allow owners the opportunity to make a fair return. Additionally, the system should reduce administrative "red tape," reduce unnecessary paperwork, and be easy to administer, in contrast to the current system which is complicated and burdensome for the provider and the program.

Unlike the existing payment system, the prospective methodology must provide incentives for efficient operation in order to restrain the growth in costs. Efficiency would be encouraged through the use of pre-determined rates. Providers able to keep their costs below the prospective rate or a target level would retain the savings for operating efficiently. Conversely, providers unable to keep their costs below the prospective rate should be responsible for incuring the loss. Additionally, as in any viable business, an opportunity for adequate return on investment and fair recognition of property costs are needed for renovation, upkeep, and future development. Such fundamentals must be part of the Medicare payment system.

There are obviously various ways of constructing a prospective payment sytem for Medicare. We will present two possible approaches, both of which incorporate the fundamentals outlined above. The first is a formula approach whereby a ceiling or target rate is established. Based on a facility's costs a projected prospective rate is calculated. If the projected rate is less than the target/ceiling a profit factor would be added to the facility's rate as a reward and incentive for operating efficiently. The sum would result in the prospective rate. The rates in this system would thus be established based on each facility's costs.

The second is a flat fee schedule or rate chart approach. Under this approach Medicare would establish a rate to be paid for all SNFs in a geographical area. The rate to be paid would be made public and all facilities in that area would receive that particular prospective rate for Medicare patients. Facilities would not have to submit cost reports since the rate would be established independently of their particular costs. In composing the prospective rate for a geographical area, however, the program would need to build in the fundamentals of an opportunity for profit, fair recognition of property costs, and incentives for efficiency.

In summary, we believe that Congress needs to act now to adopt a prospective payment system for nursing homes under Medicare and that the program cannot afford to continually delay in this area. Such a system would increase participation by SNFs in Medicare, reduce the back-up of Medicare patients in hospitals, and reduce the growth of provider costs. Thus, Medicare patients would be able to receive the medically appropriate level of care in the least costly setting. Moreover, the use of prospective payments for nursing homes would enable the program to instill market forces into the payment system and gain valuable experience before applying such a system to the more costly hospital component of the program.

Medicaid Reduction for Optional Services and Optional Recipients

AHCA strongly opposes the Administration's proposal to cut by 3 percentage points the federal Medicaid matching rate to states for coverage of optional services and optional groups of individuals. Long term health care services to the elderly poor, mentally retarded and other low income Americans would be severely harmed by this proposal which would be a $600 million cut in FY83 federal Medicaid spending. Almost 61 percent of the cost for optional services and recipients in FY79 was directly spent for the care of residents in nursing homes.

The Administration, in presenting its budget recommendations, leaves the impression that "optional" is synonymous with "unnecessary" or "less than esstential." In several instances this is clearly not the case. Indeed, it can be persuasively argued that many of the optional recipients and optional services are of a higher priority than some of the required coverages. Some services in fact are life sustaining. The fact is that while they are statutorily "optional," every state provides one or more of the optional services and has selected one or more of the optional groups for coverage.

With regard to long term health care, the largest optional recipient group is the "medically needy" who are individuals with income too high for welfare but who have incurred major medical expenses. Most of the residents in nursing homes who are Medicaid eligible fall within the medically needy category. The primary optional service that is provided by intermediate care facilities (ICFs) which are nursing homes providing regular medical, social and rehabilitative services for individuals not capable of independent living. Each and every one of the 49 states participating in the Medicaid program include the ICF program as a component of their service package.

The impact of shifting the costs to the states under this proposal would be both severe and inequitable. The states would have to increase spending for optional services and optional recipients by 9.8 percent to 26.4 percent just to offset the proposed 3 percent reducton in federal cuts in matching for optional features plus the 4 percent overall Medicaid cut enacted in the 1981 Omnibus Budget Reconciliation Act.

The following page is a table which shows for each state the following: 1) the percentage of federal spending for optional aspects which is devoted to long term care and 2) the percentage increase in state spending for FY83 which would be needed to maintain current optional aspects as a result of this proposed reduction and the four percent across-the-board payment reduction enacted in the 1981 Omnibus Budget Reconciliation Act. An appendix to the statement provides a breakout for each state of federal

Impact of Administration's Proposed Medicaid Reduction for Optional Services and Optional Groups

State	Percentage of Medicaid Payments for Optional Services and Optional Groups Expended for Long Term Care Services[1]	Percentage Increase in State's Medicaid Payments Needed to Offset Combined Impact of Proposed Reduction and 1981 OBRA Reduction
Alabama	74.9%	19.8%
Alaska	88.6	9.8
Arkansas	71.1	20.7
California	37.5	9.8
Colorado	-	10.4
Connecticut	63.3	9.8
Delaware	77.9	9.8
Florida	65.1	12.4
Georgia	70.6	16.4
Hawaii	58.5	9.8
Idaho	74.7	15.9
Illinois	44.1	9.8
Indiana	74.1	11.9
Iowa	78.6	11.4
Kansas	66.8	10.5
Kentucky	63.8	17.5
Louisiana	73.2	16.7
Maine	67.3	19.4
Maryland	66.2	9.8
Massachusetts	66.3	10.8
Michigan	63.2	9.8
Minnesota	76.4	11.1
Mississippi	53.7	26.4
Missouri	56.2	13.4
Montana	69.6	15.8

State	Percentage of Medicaid Payments for Optional Services and Optional Groups Expended for Long Term Care Services[1]	Percentage Increase in State's Medicaid Payments Needed to Offset Combined Impact of Proposed Reduction and 1981 OBRA Reduction
Nebraska	75.1%	12.4%
Nevada	64.1	9.8
New Hampshire	78.4	13.0
New Jersey	58.9	9.8
New Mexico	66.6	17.0
New York	-	10.0
North Carolina	56.8	17.4
North Dakota	65.0	14.1
Ohio	59.0	11.3
Oklahoma	69.0	13.2
Oregon	71.0	10.6
Pennsylvania	49.0	11.9
Rhode Island	66.7	12.3
South Carolina	73.3	19.5
South Dakota	90.0	17.6
Tennessee	69.3	17.9
Texas	84.2	11.5
Utah	69.4	18.0
Vermont	64.4	17.9
Virginia	68.2	11.9
Washington	65.0	9.8
West Virginia	57.6	17.5
Wisconsin	69.6	12.4
Wyoming	-	9.8

– data not available

[1] source : State Medicaid Tables FY79 (HCFA) ; Alaska and Massachusetts FY76

Medicaid spending for each optional long term care service and long term care services for optional groups of recipients. Both sets of data were prepared by AHCA based on unpublished FY79 Medicaid statistics.

Medicare Skilled Nursing Care Definition

One of the major ways for Medicare to provide more economical and appropriate services is to allow SNF coverage for a broader range of patient needs. Medicare narrowly limits coverage to patients who require daily nursing care or have rehabilitation potential. A difficult and common situation for nursing home administrators is to have to explain to Medicare patients and their families the realities of the restricted extended care coverage. The Medicare program has not adapted its SNF coverage for the past ten years to take better advantage of the services which can be provided in today's long term health care facilities. In particular, AHCA recommends that Medicare allow SNF coverage for care of the terminally ill.

We are aware of the Chairman's bill to provide Medicare coverage for hospice care.

We urge consideration be given to the immediate opportunity to make substanial progress by making this cost-effective expansion in SNF coverage. Long term health care facilities do have, unfortunately, much experience in care of the dying. But Medicare does not recognize this as a sufficient patient need for SNF coverage. Yet SNFs are often a more appropriate setting and certainly much less costly alternative to hospitals in which most of the Medicare terminal care is currently provided.

Terminally ill Medicare patients, the Hospital Insurance Trust Fund, and skilled nursing facilities could receive immediate benefit from the utilization of existing providers, even with the current 100 day limit and patient co-insurance, until the major complex issues about hospice cost controls, provider requirements, and service packages are resolved.

Another cost-effective opportunity utilizing long term health care facilities AHCA recommends is for Medicare patients receiving chemotherapy or radiation therapy to stay in non-hospital settings. Skilled nursing and intermediate care facilities would be well suited to handle the nursing and convalescent needs of such cancer patients.

Medicare SNF Prior Hospitalization Requirement

AHCA recommends the elimination of the minimum three day prior hospitalization requirement for Medicare SNF coverage as proposed in S. 1754 by Senator Heinz and eight co-sponsors. This change would provide Medicare beneficiaries with greater flexibility in their long term care coverage and result in lowering overall costs for both the patient and the Medicare program. The removal of the requirement would recognize the legitimate needs of individuals who require only skilled nursing services.

Because the cost of Medicare services in an SNF is far less than in a hospital, the potential for Medicare cost savings is obvious.

The most thorough, objective examination to date on this issue is the recently completed three-year HCFA demonstration projects in Oregon and Massachusetts and evalution report by Abt Associates, Inc. The record shows likely Medicare savings would result from elimination of the requirement. We know of no other public or private health plan which finds value in such a requirement.

The current restriction is arbitrary, unnecessary and burdensome. There are many individuals who are otherwise eligible for skilled nursing care but because they are not acutely ill or do not require the complete and costly diagnostic and therapeutic resources available in hospitals cannot be admitted to a SNF with Medicare eligibility. There are also those who "game" the program by arranging for unnecessary (and costly) hospital stays in order to become eligible for Medicare SNF benefits. In addition, there are individuals receiving hospital care who would benefit as much from SNF care but who are not transferred because of the paperwork (e.g., transfer of medical records, treatment plan) and the financial disincentives (e.g., no cost sharing is required after the hospital deductible until the 61st day).

To the extent that the three-day requirement was intended to assure a medical evaluation of the individual's condition, we believe that controls such as physician certification and concurrent utilization review can provide the necessary assurance and satisfatorily replace the expensive hospital "gatekeepers."

Medicare "Spell of Illness" Definition

AHCA recommends eliminating inconsistencies in the "spell of illness" definition so that a "spell" ends when a beneficiary is neither under Medicare inpatient hospital nor SNF coverage followed by the requisite time period. In general, the Medicare program limits the duration of covered services to the period between the beginning and ending of a "spell of illness" Under present law,a Medicare beneficiary must remain for 60 consecutive days out of a hospital or SNF in order to renew Medicare eligibility for these benefits.

There are inconsistencies in the SNF criteria used to start and end a spell of illness. For purposes of starting a spell of illness and receiving benefits, the beneficiary must be in a facility which is licensed as an SNF, certified under Medicare as a SNF, and meets all of the program's requirements for participation as a SNF. However, for purposes of "classifying" facilities to determine if a patient is no longer in a "skilled nursing facility" and thus ending a spell of illness, the program uses an overly broad definition which encompasses many facilities not certified as a SNF and not eligible to participate in the program as a SNF.

Under Medicare's policies, many Medicaid intermediate care facilities are classified as providing skilled nursing care, only for purposes of ending a Medicare spell of illness. As a result, a beneficiary placed in a facility licensed as an ICF but which is classified by Medicare as providing skilled nursing care for spell of illness purposes will not receive Medicare coverage when he needs to go back to a hospital for SNF. Coverage would not be received because the spell of illness had been deemed not to have ended.

Kansas has sued the U.S. Department of Health and Human Services over this problem. The State has Medicaid ICF standards high enough that the residents of these facilities are not able to end a Medicare "spell of illness" and therefore renew their eligibility for Medicare inpatient coverage to which they are otherwise entitled.

A similar HCFA policy adversely affects beneficiary coverage for durable medical equipment (e.g., oxygen therapy, alternating pressure mattresses, and pacemaker monitors). The durable medical equipment is available to beneficiaries at home or in an institution, other than those meeting the broad definition of SNF. AHCA recommends the Part B durable medical equipment coverage be available to a beneficiary who is neither under Medicare inpatient hospital nor SNF coverage.

Medicare Waiver of Liability

AHCA recommends that the Medicare waiver of liability provision be retained as an essential element for provider relations. The wavier of liability for providers acting in "good faith" is working adequately and should be left alone.

Under the waiver of libility provision, payment for services may be made even if payment would otherwise be disallowed if both the provider and beneficiary did not know, and could not have been reasonably expected to know that the services would not be covered.

The Urban Institute report, discussed earlier, found one of the reasons for low Medicare participation of SNFs is the uncertainty and financial risk in accepting Medicare patients. They concluded the following:

> Medicare determines coverage retroactively, makes coverage for other than clearly-defined procedures contingent upon observed changes in a patient's condition, and extends coverage for relatively short periods. Furthermore, Medicare evaluates the appropriateness of nursing homes' claim submissions, and penalizes homes for submitting claims that are ultimately denied.

In addition, they found widely varying and often inconsistent intermediary intepretations of patient eligiblity based on their medical condition.

Many SNFs gave up Medicare participation about ten years ago because of massive retroactive denials of claims. The waiver of liability provision was established to extend to providers acting in "good faith" some minimal protections. This provision is not wasteful but only covers situations where it would be unreasonable to hold the provider responsible for the claim being denied. If this protection is replaced, many of the remaining providers will also be forced out of Medicare.

Medicaid Payment for Long Term Care Facilities

AHCA recommends that in setting Medicaid nursing home payments 1) states should be required to publicly disclose their back-up data and analyses and 2) the cumbersome limitation of rates to Medicare pyments be eliminated.

States have been given greater flexibility in establishing payment rates. The regulations, however, inappropriately establish a process which will enble states to receive approval of plan amendments with only minimal review or analysis by HCFA. In providing states with flexibility there must be a better balance between reducing the burden on states and ensuring that statutory requirements are satisfied.

We recommend that states be required to disclose certain data and information they have compiled and analyses they have performed to make a "finding" that the rates meet the statutory requirements. Disclosure would neither reduce states' flexibility nor impose an inappropriate burden on them. With states having increased flexibiliy and the HCFA review being so limited, it is essential that the public have the opportunity to monitor the states. At a minimum, it is necessary that providers and other outside interested parties have an opportunity to bring to the states attention any factual errors in their data.

Finally, the Medicare upper limit should be eliminated because it is unnecessary and inappropriate when applied to state's prospective payment systems. With tightening state budgets and increasing fiscal restraint, states will not be paying excessive rates to long term care facilities. In fact, states will be using payment systems which encourage efficient operations and cost containment, in order to restrain the growth of costs. Over two-thirds of the states use prospective payment systems which provide incentives for efficient operations and cost containment and almost all states include efficiency incentives. The application of an upper limit based on the Medicare retrospective system to the states' prospective systems is inappropriate, discourages prospective systems, and ignores the benefits of prospective rates and efficiency incentives.

Family Responsibiity for Medicaid Long Term Care Costs

AHCA recommends that states be provided with increased flexibility to implement measures for families to have some financial responsibility for the cost of Medicaid nursing home services to their elderly members.

With the amount of Federal funds available to the states for Medicaid being restricted and with state budgets being tightened, the states need flexibility to be innovative and develop programs which place some of the financial responsibility on families, where appropriate, for Medicaid patients in nursing homes. If the Medicaid program can no longer afford to pay for the many recipients in need of long term care services, then states should be given maximum flexibility to develop appropriate methods for having adult children of institutionalized Medicaid recipients contribute to the cost of their parents' care.

The Administration's proposal provides states some flexibility but is limited in scope and should be expanded to provide the Secretary authority to grant states a waiver to implement "family responsibility" programs. This waiver authority would provide states flexibility to a develop program tailored to the circumstances in their particular state.

Medicaid Copayment Requirements

AHCA recommends that any Medicaid copayment, under existing state authority or proposals for new authority, not apply to recipients in nursing homes.

Medicaid recipients in nursing homes are permitted to keep a nominal amount (e.g. $25) of their monthly income but must contribute the remainder of their income toward the cost of nursing home care. Thus the program already imposes substantial cost sharing requirements on recipients in nursing homes.

The Administration has proposed requiring copayments for services by physicians, clinics, and hospital outpatient departments. Individuals in nursing homes are visited regularly by physicians and sometimes receive services from a hospital outpatient departments. We recommend that recipients in nursing homes who also receive these services be exempted from an additional cost sharing. If these copayments were applied to recipients in nursing homes, the recipient would have to pay the copayment out of the nominal personal needs allowance since all of the recipients remaining income is contributed to the cost of nursing home care. The funds from the monthly personal needs allowance is intended for personal comfort items and other purchases, not medical services. Requiring institutionalized recipients who contribute almost their entire monthly income to the cost of their nursing home care to also pay copayments on physician visits and other services is unreasonable and unwarrented even in these times of fiscal constraint.

Medicare and Medicaid Utilization of Physician Assistants and Nurse Practitioners

Federally financed demonstrations have proven that physician assistants and nurse practitioners can perform cost effective and high quality services which traditionally have been provided by physicians. Physicians extenders have proven utility for monitoring care, providng routine medical services, and appropriately involving the supervisory physician if major medical problems develop.

Congress has already recognized the value of physician assistants and nurse practitioners to augment physicians in rural clinics. Long term health care faiclities are also appropriate settings for their utilization.

The Medicare and Medicaid programs require periodic physician visits of long term care patients and periodic recertification of their continued need for care. Congress permitted in the 1981 Omnibus Budget Reconciliation Act that Medicaid recertifications could be made by physician extenders, under the supervision of a physician. AHCA recommends that physician assistant and nurse practitioners, acting under the supervision of a physician and within the scope of their license, be allowed to conduct Medicare and Medicaid required visits and Medicare recertifications.

Medicaid Periodic Recertification

There is a federal requirement that every 60 days Medicaid long term care facility patients be recertified for the need for continued care. The nature of most Medicaid patients is that their condition seldom changes, at least at that frequency. Physicians recognize this reality and so their involvement is often one of "paper compliance." It should be noted that although the facility is held responsible for timely recertification, the facility is not able to enforce this federal requirement on physicians.

Longer recertifications periods, based on actual patient conditions, are medically reasonable and administratively appropriate. Longer recertifications would be an effective way of reducing costs since they would eliminate unnecessary physician visits while maintaining quality of care.

Congress, in last year's reconciliation act, made some progress in this regard by allowing recertification to be made for up to 12 months for patients in public intermediate care facilities for the mentally retarded (ICF/MRs). AHCA recommends that the duration of Medicaid recertifications be based on the physician judgement of individual patient conditions and be permitted for up to 12 months.

Medicaid Waivers for Home and Community-Based Care

AHCA recommends some cost and patient safeguards to the recently enacted provision for states to seek waiver of certain federal requirements so as to provide home and community-based services to Medicaid recipients in need of long term care.

- o Determinations of average per capita expenditures under a waiver should include the costs of other major federal benefits which would not be provided to Medicaid nursing home patients, such as most Medicare benefits, Supplemental Security Income (except for $25 for personal allowance), food stamps, housing assistance, and social services. Limiting cost comparisons to Medicaid services only is not fiscally prudent.
- o States should be required to specify for each type of service covered their requirements for provider eligibility, staff qualifications and training, quality assurance and utilization review as well as estimates of cost and utilization.
- o Patient assessment and written plans for care should be developed only by a qualified individual such as a physician, registered nurse, or licensed staff member of a long term care facility or home health agency. Patient assessments should include an assessment of the total needs of a person, notably medical, social, and functional needs.

Utilization Review

Utilization review, the process designed to assure that patients receive the appropriate amount and level of care, AHCA recommends be revised. The seemingly straightforward provisions 1861(j)(8) and (k) cause paperwork, administration and professional burdens that we believe cannot be justified. Some of the problems include:

- One hundred percent review, review of all patients, leaves no room for a flexible utilization review program. While this may be only a minor problem with a small number of skilled nursing facilty Medicare patients, the concept is adopted by Medicaid where it constitutes an impractical demand.

- Review by committee or group of physicians has proven to be an unaffordable and uncessary requirement. Experience with the Professional Standards Review Organization (PSRO) program demonstrated that nurse and other reviewers can adequately determine the need for services. We recommend that 1861(k)(2), the requirement that utilization review be only by physician committee, be deleted.

- A problem exists when a state receives a Medicaid waiver by developing an effective alternate utilization review program, but the Medicare program retains the utilization review committee structure. This necessitates the imposition of two different review programs in the same facility. We suggest that the Secretary be given flexibility and incentive to impose the most cost effective, uniform utilization review procedure for each provider, no matter what federal program is involved.

There are three issues related to long term care and within the Committee's jurisdiction we wish to discuss briefly.

Pass Through of Supplemental Security Income Cost of Living Increases

AHCA is opposed to the Administration's proposal to eliminate the mandatory pass through of federal cost of living increases of Supplemental Security Income (SSI) benefits. If enacted, this proposal could spell disaster for our poor aged, blind and disabled citizens. Forty-one states provide these additional payments which enable the beneficiary to meet the cost of living in the state

The pass through requirement in effect prevents states from reducing state payments when federal payments increase. There is a good reason to believe that if the requirement is lifted, states will resume the practice of negating the federal increases. The SSI recipient would receive the same combined federal and state benefit they were receiving before the increase, but would not receive the additional money provided by the cost of living increase.

Many residents depend on SSI benefits to purchase the care provided by licensed residential care facilities, such as homes for the aged and retirement homes. The overhead costs of the facilities will continue to rise. These costs must be paid by the recipients of the care if the homes are to continue to operate. Inadequate SSI payments will not allow beneficiaries to purchase the care provided by licensed facilities. The result will be their exodus to unlicensed, substandard homes which are unsafe and provide inadequate or no care.

Industrial Development Bonds

AHCA is deeply concerned over recent proposals to eliminate or severely restrict Industrial Development Bonds (IDBs) and other forms of tax-exempt bonds. AHCA recommends that Congress retain the use of tax-exempt IDBs for health care institutions such as nursing homes and exclude nursing homes from any new restrrictions.

Industrial Development Bonds are extremely important to nursing home providers and the milions of elderly, chronically ill, and convalescent Americans who need long term health care. The use of IDBs by our members has grown in recent years. The need for this form of financing will increase in the coming years and the importance that IDBs will play in the availability of health care services cannot be overlooked.

There is presently a shortage of nursing home beds. Worsening the current situation is that the demographics of the aging population indicate that thousands of new beds will be needed in this decade to continue to provide services to elderly individuals in need of care. The capital demand to construct these needed beds will be enormous and IBDs are a critical source of the capital. Without Industrial Development Bonds, the potential exists for a severe shortage of capital for developing the necessary nursing home beds and services because the financial community will not provide sufficient capital. Thus, eliminating or restraining IDBs may be equivalent to halting desperately needed expansion in the long term health care area.

Another consideration is that the Federal Medicaid and Medicare programs have significant expenditures for nursing home care provided to covered individuals. To the extent that the cost of financing long term care facilities increases, because IDBs are no longer available, the costs of the Medicaid and

Medicare programs of purchasing these services will also increase. Therefore, the potential exists that not only will needed long term care services not be available because of inadequate growth in the industry, but also the cost of services to the Medicaid and Medicare programs will increase because a more expensive financing method would have to bed used in lieu of IDBs.

We recognize that there have been abuses in the use of Industrial Development Bonds by some commercial firms. However, rather than totally eliminating or restricting IDBs for all firms, Congress should target its efforts at the specific abuses. Nursing homes and other health care institutions are appropriate users of IDBs and should not be penalized along with firms which have abused this benefit. Health care institutions, and nursing homes in particular, exist for the public good, provide necessary and critical services which benefit the community, stimulate the local economy, and create a significant number of jobs.

Tax Incentives for Family Contribution to Elderly Health Payments

Despite Medicare and Medicaid, more than one-third of the elderly's health expenses are paid from private sources, usually personal out-of-pocket expenses. This situation will worsen as a result of government spending cutbacks in public health programs.

The number of health cost burden for the elderly or their families is nursing home care. In 1978, the private health care expenditure for the elderly was $747 per capita. Of that total $279, or 37 percent, went for nursing home care. Half of all catastrophic health costs are incurred by nursing home patients.

AHCA recommends that tax incentives be provided to encourage and help families contribute to this private cost burden until public benefits are expanded. Consideration should be given to such proposals allowing the deduction of nursing home and home health care expenses paid by families on behalf of their relatives.

Thank you for the opportunity to present AHCA's budget recommendations for Medicare and Medicaid. We appreciated your willingness to work with us last year to enact cost-effective Medicare and Medicaid policies. There are opportunities for new policies which would conserve program spending, improve service to your constituents, and enhance the provision of long term care services. We look forward to working with you to enact them this year.

Medicaid Payments for Optional Services for the Categorically Needy and All Services for the Medically Needy + Optional Categorically Needy

UNITED STATES

	$ (in millions) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 883	$ 2,250	$ 3,133	31.6	760,762
SNF	*	1,801	1,801	18.1	369,373
ICF-MR	571	532	1,103	11.1	115,165
				60.8	1,245,300
Other[1]	1,519	2,368	3,887	39.2	
Total	$ 2,973	$ 6,951	$ 9,924	100%	

ALABAMA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$21,774	$ 36,976	$ 58,750	49.5	12,144
SNF	*	30,189	30,189	25.4	8,030
ICF-MR	-	-	-	-	-
				74.9	20,174
Other[1]	24,306	5,514	29,820	25.1	
Total	$46,080	$ 72,679	$ 118,759	100%	

ALASKA

	$ (in thousands) - FY76				FY76
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 3,182	$ -	$ 3,182	54.0	854
SNF	*	-	-	-	-
ICF-MR	2,026	11	2,037	34.6	200
				88.6	1,054
Other[1]	516	158	674	11.4	
Total	$ 5,724	$ 169	$ 5,893	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

ARKANSAS

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 34,319	$ 47,341	$ 81,660	57.6	17,014
SNF	*	19,129	19,129	13.5	4,792
ICF-MR	-	-	-	-	-
				71.1	21,806
Other[1]	23,403	17,491	40,894	28.9	
Total	$ 57,722	$ 83,961	$141,683	100%	

CALIFORNIA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 16,360	$ 18,049	$ 34,409	2.8	9,666
SNF	*	420,183	420,183	34.7	80,560
ICF-MR	-	-	-	-	-
				37.5	90,228
Other[1]	278,217	479,843	758,060	62.5	
Total	$ 294,577	$ 918,075	$1212,652	100%	

COLORADO

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ -	$ -	$ -	-	9,505
SNF	*	-	-	-	-
ICF-MR	-	-	-	-	1,610
					11,115
Other[1]	-	-	-	-	
Total	$ -	$ -	$ -	100%	

CONNECTICUT

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 439	$ 15,483	$ 15,922	6.9	4,297
SNF	*	130,874	130,874	56.3	23,910
ICF-MR	9	223	232	.1	47
				63.3	28,254
Other[1]	17,784	67,457	85,241	36.7	
Total	$ 18,232	$ 214,037	$ 232,269	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

DELAWARE

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 3,915	$ 7,336	$ 11,251	51.1	1,189
SNF	*	277	277	1.3	139
ICF-MR	3,566	2,049	5,615	25.5	449
				77.9	1,777
Other[1]	3,499	1,364	4,863	22.1	
Total	$10,980	$ 11,026	$ 22,006	100%	

FLORIDA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$11,517	$ 48,651	$60,168	37.6	16,264
SNF	*	35,757	35,757	22.3	10,201
ICF-MR	5,637	2,590	8,227	5.2	675
				65.1	27,140
Other[1]	40,581	15,265	55,846	34.9	
Total	$57,735	$102,263	$159,998	100%	

GEORGIA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$25,237	$ 67,638	$ 92,975	40.7	20,262
SNF	*	40,753	40,753	17.8	11,144
ICF-MR	2,400	25,238	27,638	12.1	1,559
				70.6	32,965
Other[1]	44,926	22,204	67,130	29.4	
Total	$ 72,563	$ 155,933	$228,496	100%	

HAWAII

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 5,525	$ 10,050	$ 15,575	27.9	1,732
SNF	*	17,129	17,129	30.6	2,045
ICF-MR	-	-	-	-	-
				58.5	3,777
Other[1]	10,572	12,618	23,190	41.5	
Total	$16,097	$ 39,797	$ 55,894	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

IDAHO

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 268	$ 10,734	$ 11,002	32.4	2,342
SNF	*	7,388	7,388	21.7	1,640
ICF-MR	74	6,920	6,994	20.6	463
				74.7	4,445
Other[1]	2,752	5,873	8,625	25.3	
Total	$3,094	$ 30,915	$ 34,009	100%	

ILLINOIS

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 47,916	$ 166,230	$ 214,146	33.8	56,033
SNF	*	64,999	64,999	10.3	17,948
ICF-MR	-	-	-	-	-
				44.1	73,981
Other[1]	116,873	237,833	354,706	55.9	
Total	$164,789	$ 469,062	$ 633,851	100%	

INDIANA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 28,448	$ 92,558	$ 121,006	52.0	22,785
SNF	*	30,560	30,560	13.1	5,838
ICF-MR	9,240	11,828	21,068	9.0	1,881
				74.1	30,504
Other[1]	18,986	41,331	60,317	25.9	
Total	$ 56,674	$ 176,277	$ 232,951	100%	

IOWA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 14,340	$ 70,421	$ 84,761	55.9	20,403
SNF	*	1,251	1,251	.8	458
ICF-MR	20,853	12,301	33,154	21.9	1,685
				78.6	
Other[1]	17,238	15,242	32,480	21.4	22,546
Total	$52,431	$ 99,215	$151,646	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

KANSAS

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$13,366	$ 46,171	$ 59,537	44.0	14,626
SNF	*	1,751	1,751	1.3	934
ICF-MR	21,074	8,030	29,104	21.5	3,674
				66.9	19,234
Other[1]	10,775	34,184	44,959	33.2	
Total	$45,215	$ 90,136	$135,351	100%	

KENTUCKY

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$22,967	$ 41,267	$64,234	42.4	14,411
SNF	*	17,477	17,477	11.6	4,541
ICF-MR	11,128	3,745	14,873	9.8	632
				63.8	19,584
Other[1]	28,293	26,609	54,902	36.2	
Total	$62,388	$ 89,098	$151,486	100%	

LOUISIANA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 43,672	$ 78,397	$ 122,069	50.0	26,440
SNF	*	2,803	2,803	1.2	874
ICF-MR	38,464	15,337	53,801	22.0	4,065
				73.2	31,379
Other[1]	46,678	18,752	65,430	26.8	
Total	$128,814	$ 115,289	$ 244,103	100%	

MAINE

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 9,962	$ 43,101	$ 53,063	64.3	9,575
SNF	*	2,462	2,462	3.0	530
ICF-MR	-	-	-	-	-
				67.3	10,105
Other[1]	9,531	17,472	27,003	32.7	
Total	$19,493	$ 63,035	$ 82,528	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

MARYLAND

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$18,941	$ 71,161	$ 90,102	64.5	14,587
SNF	*	2,340	2,340	1.7	793
ICF-MR	-	-	-	-	-
				66.2	15,380
Other[1]	15,916	31,270	47,186	33.8	
Total	$34,857	$ 104,771	$ 139,628	100%	

MASSACHUSETTS

	$ (in thousands) - FY76				FY76
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$22,860	$ 83,439	$106,299	30.8	29,553
SNF	*	75,343	75,343	21.9	-
ICF-MR	17,699	29,308	47,007	13.6	4,862
				66.3	34,415
Other[1]	44,156	72,163	116,319	33.7	
Total	$84,715	$ 260,253	$344,968	100%	

MICHIGAN

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 30,716	$ 91,338	$ 122,054	22.2	24,008
SNF	*	116,072	116,072	21.1	22,374
ICF-MR	71,405	38,466	109,871	19.9	5,511
				63.2	51,893
Other[1]	109,571	93,410	202,981	36.8	
Total	$211,692	$ 339,286	$ 550,978	100%	

MINNESOTA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$21,921	$ 69,724	$ 91,645	24.9	23,251
SNF	*	117,496	117,496	31.9	19,673
ICF-MR	38,961	33,383	72,344	19.6	11,464
				76.4	54,388
Other[1]	26,734	60,093	86,827	23.6	
Total	$87,616	$ 280,696	$ 368,312	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

MISSISSIPPI

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 5,690	$ 8,136	$ 13,826	16.5	3,652
SNF	*	24,250	24,250	29.0	5,722
ICF-MR	2,670	4,142	6,812	8.2	841
				53.7	10,215
Other[1]	23,291	15,408	38,699	46.3	
Total	$31,651	$ 51,936	$ 83,587	100%	

MISSOURI

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$40,936	$ 33,655	$ 74,591	44.8	16,297
SNF	*	1,052	1,052	.6	525
ICF-MR	-	17,956	17,956	10.8	1,508
				56.2	18,330
Other[1]	26,229	46,756	72,985	43.8	
Total	$67,165	$ 99,419	$166,584	100%	

MONTANA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$3,690	$ 19,087	$ 22,777	55.9	4,881
SNF	*	1,745	1,745	4.3	930
ICF-MR	2,308	1,510	3,818	9.4	315
				69.6	6,126
Other[1]	3,762	8,674	12,436	30.4	
Total	$9,760	$ 31,016	$ 40,776	100%	

NEBRASKA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$13,186	$ 26,335	$ 39,521	55.2	9,267
SNF	*	4,200	4,200	5.9	838
ICF-MR	7,135	2,884	10,019	14.0	808
				75.1	10,913
Other[1]	8,239	9,560	17,799	24.9	
Total	$28,560	$ 42,979	$ 71,539	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

NEVADA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 1,224	$ 12,105	$ 13,329	50.5	2,060
SNF	*	974	974	3.7	563
ICF-MR	72	2,550	2,622	9.9	168
				64.1	2,791
Other[1]	1,300	8,169	9,469	35.9	
Total	$ 2,596	$ 23,798	$ 26,394	100%	

NEW HAMPSHIRE

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 1,176	$ 32,547	$ 33,723	70.0	4,706
SNF	*	1,116	1,116	2.3	423
ICF-MR	47	2,859	2,906	6.1	293
				78.4	5,422
Other[1]	3,059	7,359	10,418	21.6	
Total	$ 4,282	$ 43,881	$ 48,163	100%	

NEW JERSEY

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 53,680	$ 210,771	$ 264,451	56.8	30,978
SNF	*	9,792	9,792	2.1	2,813
ICF-MR	-	-	-	-	-
				58.9	33,791
Other[1]	68,519	123,010	191,529	41.1	
Total	$ 122,199	$ 343,573	$ 465,772	100%	

NEW MEXICO

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 4,530	$ 9,510	$ 14,040	47.7	2,986
SNF	*	537	537	1.8	250
ICF-MR	3,843	1,184	5,027	17.1	460
				66.6	3,696
Other[1]	7,227	2,594	9,827	33.4	
Total	$ 15,600	$ 13,825	$ 29,425	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

NEW YORK

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ -	$ -	$ -	-	78,012
SNF	*	-	-	-	-
ICF-MR	-	-	-	-	16,548
					94,560
Other[1]	-	-	-	-	
Total	$ -	$ -	$ -	100%	

NORTH CAROLINA

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$13,993	$ 43,440	$ 57,433	25.6	12,910
SNF	*	37,546	37,546	16.7	9,581
ICF-MR	19,272	13,259	32,531	14.5	1,837
				56.8	24,328
Other[1]	42,900	54,082	96,982	43.2	
Total	$76,165	$ 148,327	$ 224,492	100%	

NORTH DAKOTA

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ 1,320	$ 6,960	$ 8,280	25.3	1,769
SNF	*	12,994	12,994	39.7	2,690
ICF-MR	-	-	-	-	-
				65.0	4,459
Other[1]	2,436	8,994	11,430	35.0	
Total	$ 3,756	$ 28,948	$ 32,704	100%	

OHIO

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ 29	$ 84,247	$ 84,276	16.7	17,837
SNF	*	150,800	150,800	30.0	27,914
ICF-MR	26	62,000	62,026	12.3	3,869
				59.0	49,620
Other[1]	34,046	172,660	206,706	41.0	
Total	$ 34,101	$ 469,707	$ 503,808	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

OKLAHOMA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 71,310	$ 39,904	$ 111,214	53.5	23,207
SNF	*	-	-	-	-
ICF-MR	204	32,065	32,269	15.5	1,921
				69.0	25,128
Other[1]	25,114	39,320	64,434	31.0	
Total	$ 96,628	$ 111,289	$ 207,917	100%	

OREGON

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 8,450	$ 37,246	$ 45,696	38.8	11,191
SNF	*	4,886	4,886	4.2	1,434
ICF-MR	1,473	31,541	33,014	28.0	2,299
				71.0	14,924
Other[1]	10,914	23,201	34,115	29.0	
Total	$ 20,837	$ .96,874	$ 117,711	100%	

PENNSYLVANIA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 20,901	$ 71,134	$ 92,035	10.5	20,674
SNF	*	160,137	160,137	18.2	29,837
ICF-MR	81,860	96,703	178,563	20.3	17,540
				49.0	68,051
Other[1]	122,636	325,576	448,212	51.0	
Total	$ 225,397	$ 653,550	$ 878,947	100%	

RHODE ISLAND

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 7,126	$ 36,315	$ 43,441	45.1	7,166
SNF	*	3,247	3,247	3.4	480
ICF-MR	9,493	7,999	17,492	18.2	1,115
				66.7	8,761
Other[1]	13,148	18,995	32,143	33.3	
Total	$ 29,767	$ 66,556	$ 96,323	100%	

- no data reported
* mandatory service
[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services
Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

SOUTH CAROLINA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 7,377	$ 38,612	$ 45,989	37.9	9,496
SNF	*	27,662	27,662	22.8	7,655
ICF-MR	4,707	10,561	15,268	12.6	1,601
				73.3	18,752
Other[1]	21,915	10,440	32,355	26.7	
Total	$ 33,999	$ 87,275	$121,274	100%	

SOUTH DAKOTA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 5,980	$ 15,192	$ 21,172	56.8	4,658
SNF	*	2,258	2,258	6.1	687
ICF-MR	5,804	4,316	10,120	27.1	812
				90.0	6,157
Other[1]	1,920	1,791	3,711	10.0	
Total	$ 13,704	$ 23,557	$ 37,261	100%	

TENNESSEE

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 30,240	$ 85,034	$ 115,274	50.1	21,331
SNF	*	3,148	3,148	1.4	2,121
ICF-MR	27,540	13,373	40,913	17.8	2,224
				69.3	25,676
Other[1]	39,895	30,738	70,633	30.7	
Total	$ 97,675	$ 132,293	$ 229,968	100%	

TEXAS

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$112,827	$ 243,761	$ 356,588	58.2	81,882
SNF	*	26,976	26,976	4.4	8,249
ICF-MR	92,798	39,401	132,199	21.6	11,071
				84.2	101,202
Other[1]	66,722	30,205	96,927	15.8	
Total	$272,347	$ 340,343	$ 612,690	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

[illegible]

UTAH

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ 6,503	$ 13,213	$ 19,716	31.8	5,471
SNF	*	8,029	8,029	12.9	2,517
ICF-MR	6,705	8,609	15,314	24.7	812
				69.4	8,800
Other[1]	6,000	13,029	19,029	30.6	
Total	$ 19,208	$ 42,880	$ 62,088	100%	

VERMONT

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ 2,769	$ 13,739	$ 16,508	43.3	2,939
SNF	*	697	697	1.8	270
ICF-MR	4,918	2,420	7,338	19.3	511
				64.4	3,720
Other[1]	4,476	9,070	13,546	35.6	
Total	$ 12,163	$ 25,926	$ 38,089	100%	

VIRGINIA

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ 30,204	$ 76,749	$ 106,953	53.3	15,739
SNF	*	3,880	3,880	1.9	1,552
ICF-MR	16,200	9,859	26,059	13.0	2,956
				68.2	20,247
Other[1]	27,656	36,124	63,780	31.8	
Total	$ 74,060	$ 126,612	$ 200,672	100%	

WASHINGTON

Service	$ (in thousands) - FY79 Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	FY79 Number of Recipients
ICF	$ 3,342	$ 30,770	$ 34,112	16.6	6,038
SNF	*	63,725	63,725	31.0	14,418
ICF-MR	35,701	-	35,701	17.4	2,379
				65.0	22,835
Other[1]	31,241	40,548	71,789	35.0	
Total	$ 70,284	$ 135,043	$ 205,327	100%	

- no data reported

* mandatory service

[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

WEST VIRGINIA

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 23,605	$ 14	$ 23,619	57.6	4,475
SNF	*	-	-	-	-
ICF-MR	-	-	-	-	-
				57.6	4,475
Other[1]	16,085	1,296	17,381	42.4	
Total	$ 39,690	$ 1,310	$ 41,000	100%	

WISCONSIN

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ 34,217	$ 28,038	$ 62,255	15.7	8,585
SNF	*	195,004	195,004	49.1	31,459
ICF-MR	14,460	4,759	19,219	4.8	2,235
				69.6	42,279
Other[1]	46,030	74,987	121,017	30.4	
Total	$ 94,707	$ 302,788	$397,495	100%	

WYOMING

	$ (in thousands) - FY79				FY79
Service	Categ. Needy	Med. Needy + Optional Categ. Needy	Total	%	Number of Recipients
ICF	$ -	$ -	$ -	-	592
SNF	*	-	-	-	-
ICF-MR	-	-	-	-	-
					592
Other[1]	-	-	-	-	
Total	$ -	$ -	$ -	100%	

- no data reported
* mandatory service
[1] Categ. Needy amount represents only optional services; Medically Needy + Opt. Categ. Needy amount represents all services

Source : Medicaid State Tables Fiscal Year 1979 (HCFA : Unpublished)

Mr. **Hermelin**. The AHCA urges the committee to reject proposals which merely shift Federal cost to others or which have severe impacts on certain types of recipients, services, or providers. With the Administration's commitment to soon bring forth two fundamental changes in Federal health care involvement—a competitive health care program and federalization of medicaid—it is particularly inappropriate to consider disparate and potentially counterproductive spending cuts. If the Congress must cut in these two programs, we suggest that there are greater opportunities to achieve savings in medicare. It is our experience that most State medicaid programs have been very aggressive and innovative in their cost containment efforts. And such State efforts will continue because of State budget problems, independent of any further Federal action.

I wish this morning to focus on two specific recommendations. First, enactment of a Medicare prospective payment system for nursing homes. And, second, our opposition to the administration's proposed cut in Federal medicaid payments for optional services and optional groups of individuals. I call your attention to a table following page 12 of the written testimony, and the appendix which provides State-by-State data on what would be the impact of these cuts.

Our first recommendation is that the medicare program can achieve significant savings and enable long-term care beneficiaries to receive the appropriate services in the least costly setting by implementing a prospective reimbursement system for skilled nursing facilities, SNF's.

There is a serious problem with the lack of participation by long-term care facilities in the medicare program. As a result, many medicare beneficiaries in need of SNF care are not able to receive the appropriate care, and they are backed up in expensive hospitals awaiting SNF placement.

Medicare's inappropriate payment system is a major reason for the lack of participation by SNF's in medicare. If medicare adopted a prospective payment system, more SNF's would participate, beneficiaries would be able to received SNF care more promptly, and the medicare program would achieve long run savings by paying for SNF care in lieu of hospital care, and by providing incentives for efficiency and cost containment.

According to a national survey conducted in 1980, there may be as many as 19,000 medicare beneficiaries backed up in hospitals waiting for a SNF bed with consequent medicare dollars being wasted. This survey indicated that medicare was paying for more than 6 million days of hospital care per year for patients for whom a bed in a SNF could not be found.

First, some relevant facts concerning medicare in nursing homes, which provides a very different picture than the hospital area. Nursing home services are a small component of medicare. Less than 2 percent of medicare program costs are for nursing home services. Similarly, medicare accounts for a very small proportion, approximately 2 percent, of total payments for nursing homes. About one-third of the SNF's choose not to participate in the medicare program. And many who do participate choose not to take medicare beneficiaries if other patients are available.

Congress was concerned about the inadequate access of medicare patients to SNF's, and in 1980, instructed HCFA to study the causes and the extent to which laws and regulations discourage medicare participation. In response, HCFA funded a study by the Urban Institute, which supports the finding that medicare patients do not have adequate access to SNF beds because of provider reluctance to participate in the program and/or admit medicare patients.

The use of a prospective payment system for nursing homes is not simply an untried concept when it comes to nursing homes. The virtue of prospective reimbursements are known. Over two-thirds of the State medicaid programs have successfully employed prospective payment systems for nursing homes for several years. The experience is that prospective reimbursement has proven to reduce the growth in cost. I think much less leadtime would be necessary to implement a prospective system for nursing homes than hospitals. A fiscal year 1983 proposal along this line for nursing homes I think would be entirely feasible for implementation.

There are, obviously, various ways for constructing a prospective payment system. And we would be happy to consult with the members of the committee in developing the details.

AHCA's second recommendation is to urge the committee to reject the administration's proposal to cut Federal medicaid payments to States for coverage of optional services and optional groups of individuals.

Long-term health care services to the elderly, poor, mentally retarded, and other low income Americans would be severely harmed by this proposal, which would be a $600 million cut in fiscal year 1983 medicaid spending. Please remember that last year Congress enacted deep cuts in medicaid. States, providers and recipients are only now beginning to feel the impact. And please remember also that more than 60 percent of the cost for so-called optional services and recipients is directly spent for the care of residents in nursing homes. The administration leaves the impression that "optional" is synonymous with "unnecessary" or "less than essential." This is clearly not the case. Indeed, it can be persuasively argued that many of the optional recipients and optional services are of a higher priority than some of the required services. Some services, in fact, are life sustaining. The fact is that while they are statutorily optional, every single State in the country provides one or more of the optional services, and have selected one or more of the optional groups for coverage.

With regard to long-term care the largest optional group is the medically needy. They are individuals whose income is just above the welfare level, but who have incurred major medical expenses which bring them below that level. Most of the residents in nursing homes who are medicaid eligible fall within the medically needy category.

The primary optional service is that provided by intermediate care facilities or ICF's. Each and everyone of the 49 states participating in the medicaid program include the ICF program as a component of their service package.

The fiscal impact on the States is far more severe than a 3 percent reduction would imply. The States would have to increase spending for optional services, and optional recipients, by 9.8 percent to 26.4 percent just to offset the combined impact of the proposed 3 percent cut, and the 4-percent overall medicaid cut enacted in the 1981 Omnibus Reconciliation Act.

On behalf of the AHCA, I want to thank you for the opportunity to testify before you today.

Senator DURENBERGER. Thank you very much. Let me ask you a general question. You did a very good job of pointing out the supply/demand problem of nursing home facilities in America. What would you point to as the main problem or main problems in expanding the supply to meet the current demand?

Mr. HERMELIN. Increasing the number of long-term care beds that are available for both medicare and medicaid?

Senator DURENBERGER. Right.

Mr. HERMELIN. There are, as in most instances that we have talked about today, a number of factors that contribute. Gary, would you want to address some of the specific ones?

Mr. CAPISTRANT. Well, I would say the most obvious is the medicaid reimbursement system, particularly the level of reimbursement. Half of the nursing home revenues comes from medicaid. The medicaid levels have been historically low and are becoming even lower. Another factor is limited capital resources for construction and rehabilitation. There are major needs for capital just to maintain the present service capacity to the growing elderly population. The future need for new beds is formidable.

Mr. HERMELIN. I might note that 60 percent of the nursing home patients are medicaid recipients. On one hand there are efforts to constrain Government costs, which are appropriate, particularly under the economic conditions we have today. And on the other hand, you have the demographics of an increasing aging population. Reconciling those two is going to be quite difficult.

Senator DURENBERGER. You talked about prospective reimbursement for medicare. Is there any reason why we can't treat the needy elderly in much the same fashion as we treat elderly qualified under medicare in terms of prospective reimbursement?

Mr. CAPISTRANT. I am not sure I understand the question, Senator.

Senator DURENBERGER. Well, the two sources of funding access to long-term care for the elderly at least in todays environment are medicare and medicaid. We've spoken about prospective reimbursement for medicare. Is there any reason why we can't use prospective reimbursement under medicaid for the needy elderly?

Mr. HERMELIN. As I indicated in my statement, Senator, more than 30 States have implemented prospective reimbursement systems in medicaid. More are considering it right now. It has proven, in the medicaid area, to be a restraint on the growth of program spending. Many States have put in incentives so that providers are rewarded for operating efficiently and economically. So I think the problem is more with respect to medicare that is limiting the ability to move to a prospective system. Only a few States use a retrospective system in their medicaid program.

Senator DURENBERGER. Why aren't the other 20 States implementing prospective reimbursement? Is it because of the optional nature of the services?

Mr. **Capistrant**. First of all, the States which use a prospective system are the larger States. Thus, a larger percentage of medicaid spending is made in using a prospective method than is indicated by the number of States figure. Some of the States, I would assume, just do not have enough of a medicaid nursing home program to warrant a specialized system. Obviously, as their budget situations have worsened, they are increasingly looking for more efficiency-inducing methods. Certainly if the medicare program instituted a prospective system based on the best of the State medicaid experience, I would assume that the rest of the medicaid programs would follow the medicare lead, as they do with many other services.

Senator **Durenberger**. You must know that there is authority under existing law to unify medicare reimbursement with medicaid. Medicare could pay up to 10 percent more than the State medicare can for skilled nursing facilities. As you indicated, a majority of the States are setting rates prospectively. Would you not support the implementation of existing law?

Mr. **Hermelin**. I think we would. Let it be pointed out that the Department has never issued regulations under that provision in section 249(b) of the 1972 amendments. That has been a disadvantage to those States that wanted to take advantage of that. While we think that is a useful way to go in terms of dealing almost on an experimental basis with prospective payment, nursing home providers would be more than willing to go beyond that and support a prospective reimbursement system for the entire medicare program. Since not every State uses a prospective system and some systems are better than others we think to do it under the existing law, section 249(b), would be too limited of an approach to the problem.

Senator **Durenberger**. Thank you very much. Were you going to add something to that?

Mr. **Capistrant**. I was just going to say, Senator, the provision that you indicate is do it on a State-by-State basis. If you would only take that very small step on the medicare side that we would recommend that it be made a facility choice rather than having that apply to all or none of the facilities in a State.

Senator **Durenberger**. Is the association comfortable with the proposal to federalize medicaid?

Mr. **Hermelin**. While the association has not taken an official position on it, we have raised numerous questions about it. And at this point, our opinion is that the concept is too vague. We have seen so little in terms of what it might be, in terms of eligibility, in terms of reimbursement, whether it will be used by the Federal Government as a means to restrain costs only, that we are uncomfortable until we see details. The concept itself does not bother us. But like many other vague concepts, we must hold off in terms of a specific position on it until we see some specifics. Then we will be happy to work with both the Congress and the administration in developing its impact on long-term care.

Senator **Durenberger**. I think people are faced with the prospect of having to make that decision fairly quickly. Thus, it would be very helpful to me if you would supply me with the questions you have raised and recommendations you have made about the federalization of medicaid. Or if you believe that there is a preferable alternative with a State base but with, a Federal role, would you provide us with that kind of information? You don't have to take an official association position on it, but the best thinking available in the shortest amount of time would be very helpful.

Mr. HERMELIN. We would be happy to respond to you personally on an unofficial and informal basis.

Senator DURENBERGER. Thank you very much.

Our final witness is Mr. William Samuels, legislative liaison for the National Treasury Employees Union, Washington, D.C. Bill, thank you for being here.

STATEMENT OF WILLIAM SAMUELS, LEGISLATIVE LIAISON FOR THE NATIONAL TREASURY EMPLOYEES UNION, WASHINGTON, D.C.

Mr SAMUELS. Thank you, Mr. Chairman. My name is William Samuels, legislative liaison for the National Treasury Employees Union. Mr. Chairman, Mr. Klepner was called away at the last minute and he has asked me to appear in his place. And I will summarize from our prepared remarks.

I appreciate this opportunity to present the union's view on the administration's budget submission for fiscal year 1983 concerning Government health programs. And I would like to specifically direct my remarks to that proposal which would mandate coverage of all Federal workers under the medicare system.

Let me indicate at the outset that our union is firmly opposed to the adoption of a universal medicare system. In our view, the proposal violates the principles of sound economics and of equity. Under the administration's plan, Federal employees would pay 1.3 percent of their earnings up to the current social security maximum of $32,400.00 to finance universal medicare coverage. This program would entitle Government workers with a required number of years of service to qualify for medicare at age 65.

Federal employees have not been included under medicare for sound and well advised reasons. In 1959, the Congress created a Federal employees' health benefit program to provide comprehensive health care to both active and retired Government workers. Unlike most plans at the time, the FEHB extended medical coverage to retired employees, protecting this group of individuals from the high cost of health care which must be borne by the elderly.

Six years after the creation of the FEHBP, Congress enacted a medicare law. Since Federal employees did not need nor did they desire coverage under the new health care system, Congress did not include them under this program.

The administration is now seeking to reverse this long-standing policy on the grounds that the vast majority of Government retirees will receive medicare without having to pay the payroll tax. OMB, however, has not supported this claim with any evidence. And we urge the committee to keep in mind that those Federal retirees who receive medicare do so only according to law.

Through changes in these requirements in the next few years, the social security system is itself reducing the number of employees who can work a relatively short period of time in the private sector and thereby qualify for social security or medicare. This year, work was only 32 quarters or 8 years of covered employment to receive medicare benefits. By 1990, they will be required to have 40 quarters or 10 years of social security credits to be eligible. As the number of necessary quarters steadily increases, fewer and fewer Federal retirees will be found on the medicare rolls.

The administration maintains that universal medicare coverage will help mitigate the financial difficulties of the system. Including Federal employees under medicare, however, will only increase the funding problem. In fiscal year 1983, the 1.3 percent payroll tax on the earnings of Federal employees would generate an estimated $619 million in revenues for the HI trust fund. If we assume that the 1 million individuals age 65 and older presently receiving civil service retirement annuities were also eligible for medicare and take the average payment and apply it to this group, the additional cost to medicare would be $890 million.

Moreover, Federal salaries upon which the 1.3 percent tax would be based are rising at less than one-half the rate of medicare cost increases. The disparity between revenue and outlays will only grow as the medicare tax becomes increasingly inadequate to cover the claims made by Federal retirees.

It is possible that under current funding the HI trust fund will be depleted by the end of this decade, according to the report of the National Commission on Social Security.

During the same period, Federal retirees will be drawing more from the medicare system than they will be by contributing on an annual basis. Rather than moving the HI trust fund toward solvency, the administration proposal would exacerbate its difficulties.

As we mentioned earlier, the 1.3 percent payroll tax on Federal employees would increase revenues by $619 million, while the medicare claims for this group would result in an outlay of $890 million. The $271 million shortfall could only be eliminated by requiring that Federal agencies match the employees' contribution to medicare. In order to generate these funds, agency budgets will either have to be increased or vital programs would have to be sliced. In an obvious case of having to rob Peter to pay Paul, the universal medicare coverage would drive up the cost of domestic programs or hamper the delivery of vital Government services.

During a period of soaring budget deficits, we are certain that the American people will not support unnecessary Government spending, which, in this case, would not produce any additional services. We submit that universal medicare represents a false economy both for the health care system and for beleaguered agency budgets. And should be rejected by this committee. Besides the economic considerations, however, the question of fairness to Federal employees and retirees is also important. As the representative of over 120,000 individuals who are present or former employees of the U.S. Government, we can assure the committee that our members are willing to make sacrifices along with other Americans for the economic well-being of our Nation. But it is difficult for our members to accept that for the past decade they have been forced, not asked, to bear a disproportionate share of this struggle.

The addition of universal medicare as well as the other changes in Federal pay and retirement proposed by the Reagan administration, would place yet another burden on the incomes of Federal employees and annuitants.

For example, the President's budget calls for a 5-percent pay cap on the annual comparability adjustment for Federal workers, well below wage gains reported in the private sector. In addition, premium costs under the Federal employee health benefit program have been increased by as much as 30 percent. The addition of the 1.3-percent medicare payroll tax would virtually eliminate any hope by Federal employees that their salaries would keep pace with rising costs. The medicare tax would fall most heavily on those workers at the lower end of the general schedule.

We believe that the tax is an unfair burden on all employees. Nevertheless, the fact that the deduction is a flat percentage makes it disproportionately heavy on lower paid employees.

We urge the committee to remember that approximately one-quarter of the Federal work force earns an income which the Bureau of Labor Statistics deems to be at or below the minimum budget for an urban family of four.

As you know, a special Commission is currently undertaking a comprehensive study of the future of the social security system, and will not issue its report until the end of the year. In view of this fact, we believe it would be premature to implement an aspect of universal social security coverage before the issue has been carefully studied.

In conclusion, we dispute the administration's claim that universal medicare would improve the solvency of the health care system, and would also rectify past inequities. Any initial infusion of funds into this system would only be canceled by future liabilities. We, therefore, urge this panel to reject the universal medicare proposal.

I, again, express my appreciation to you for allowing me the opportunity to appear today, and would be happy to answer any questions.

[The prepared statement of Jerry D. Klepner follows:]

JERRY D. KLEPNER, DIRECTOR OF LEGISLATION, NATIONAL TREASURY EMPLOYEES UNION

I am Jerry D. Klepner, Director of Legislation of the National Treasury Employees Union. Our union is the exclusive representative of over 120,000 U.S. government workers in numerous Federal agencies.

We appreciate this opportunity to present our views on the Administration's Fiscal Year 1983 budget submission concerning government health programs. We would like to specifically direct our remarks to that proposal which would mandate coverage of all Federal workers under the Medicare system.

Let us indicate at the outset that our union is firmly opposed to the adoption of the so-called universal Medicare scheme. In our view, the proposal violates the principles of sound economics and of equity. We know that this Committee has the awesome responsibility of examining programs which have a great impact upon the health care of millions of Americans. We are fully aware that the Medicare system is under a financial strain. Nevertheless, we submit that placing Federal workers under the program is not a viable solution.

Under the Administration's proposal, Federal employees would pay 1.3 percent of their earnings, to the current social security maximum of $32,400, to finance a universal Medicare coverage plan. This program would entitle government workers, with a required number of years of service, to qualify for Medicare at age 65. Currently, only those individuals who are eligible for social security or who pay Medicare premiums can receive benefits under this program.

To justify this change, the Office of Management and Budget (OMB) claims that in the next few years 80 percent of Federal workers over 65 will qualify for Medicare coverage on the basis of spouse earnings or periods of employment in the private sector even though they did not pay the Medicare tax for the majority of their careers. According to the Administration, universal Medicare coverage would improve the solvency of the Health

Insurance (HI) Trust Fund, which finances the system, and would constitute more equitable treatment of Federal workers.

While these contentions appear reasonable at first blush they will not withstand further scrutiny. Federal employees have not been included under Medicare for sound and well advised reasons. In 1959, Congress created the Federal Employees Health Benefit Program (FEHBP). This system provides comprehensive health care to both active and retired government workers. Unlike most plans at the time, the FEHBP extended medical coverage to retired employees, protecting this group of individuals from the high costs of health care which must be borne by the elderly. Six years after the creation of the FEHBP, Congress enacted the Medicare law. Since Federal employees did not need, nor did they desire, coverage under the new health care system, Congress did not include them in the program.

The Administration is now seeking to reverse this long-standing policy on the grounds that the vast majority of government retirees will receive Medicare without having paid the payroll tax. The OMB, however, has not supported this claim with any evidence. We urge the Committee to keep in mind that those Federal retirees who receive Medicare do so only according to the requirements of the law.

In 1965, when Medicare was created, virtually all individuals who were age 65 and older gained coverage, including former government workers. Because over 15 years have passed since that time, most of these individuals are no longer alive. Other Federal retirees who qualify for Medicare coverage do so because they are also eligible for social security as a result of periods of work in the private sector. We must emphasize that these retirees only receive benefits pursuant to the strict quidelines of the Medicare and social security laws. According to the statute, a worker must be employed in private business for a precise number of quarters in order to satisfy eligibility requirements.

Through changes in these requirements in the next few years, the social security system is itself reducing the number of employees who can work a relatively short period of time in the private sector and thereby qualify for social security or Medicare. This year, workers will need 32 quarters or eight years of covered employment to receive Medicare benefits. By 1990, they will be required to have 40 quarters or ten years of social security credits to be eligible. As the number of necessary quarters steadily increases, fewer and fewer Federal retirees will be found on the Medicare rolls.

The Administration also implies that former government workers who are eligible for Medicare on the basis of spouse earnings wrongly receive these benefits. But the truth is that these critics have focused on this small group of Federal retirees despite the fact that there are many others who benefit in a similar way. For example, individuals who are employed by charitable organizations and are not covered by social security can receive Medicare coverage if their spouses are eligible. We do not believe that it is either accurate of fair to portray Federal retirees as the beneficiaries of unintended Medicare payments when they, like other groups, have earned such benefits under the law.

The Administration also maintains that universal Medicare coverage will help mitigate the financial difficulties of the system. In reality, however, including Federal employees under Medicare will only increase the funding problems. In Fiscal Year 1983, the 1.3 percent payroll tax on the earnings of Federal employees would generate an estimated $619 million in revenue for the HI Trust Fund. If we assume that the one million individuals, age 65 and older, presently receiving civil service retirement annuities were eligible for Medicare, and take the average payment and apply it to this group, the additional cost to Medicare would be $890 million.

Moreover, Federal salaries, upon which the 1.3 percent tax would be based, are rising at less than one-half the rate of Medicare cost increases. For the period between 1978 and 1980, white collar salaries rose 12 percent, while the Medicare benefit costs increased by 27 percent. The disparity between revenue and outlays will only grow as the Medicare tax becomes increasingly inadequate to cover the claims made by Federal retirees.

It is possible that under current funding the HI Trust Fund will be depleted by the end of this decade, according to the report of the National Commission on Social Security. During this same period, Federal retirees will be drawing more from the Medicare system than they will be contributing on an annual basis. Rather than moving the HI Trust Fund toward solvency, the Administration's proposal would exacerbate its difficulties.

As we mentioned earlier, the 1.3 percent payroll tax on Federal employees would increase revenues by $619 million while the Medicare claims for this group would result in outlays of $890 million. The $271 million shortfall could only be eliminated by requiring that Federal agencies match the employee's contribution to Medicare. In order to generate these funds, agency budget would either have to be increased or vital programs would have to be slashed. In an obvious case of "robbing Peter to pay Paul" universal medicare coverage would drive up the cost of domestic programs or hamper the delivery of vital government services.

"Off budget" agencies, such as the U.S. Postal Service, would be particularly hard-hit by the Administration's proposal. The government contribution would cost the Postal Service at least $170 million in Fiscal Year 1983. However, the Administration has not recommended any means by which this additional money will be raised. Financing the Postal Service's obligation to Medicare could very likely result in higher postage rates or even the elimination of Saturday mail delivery.

A further illustration of the adverse impact of the Administration's proposal on agency spending is the potential effect on the budget of the

Internal Revenue Service where our union represents virtually all the employees. The IRS employer contribution would amount to a $24 million annual expense. Already suffering from a severe budget reduction, the agency could be forced to cutback on the enforcement of our tax laws or even further curtail taxpayer services. In either instance, the U.S. Treasury would be denied vitally needed revenue and voluntary compliance with tax laws would be seriously damaged.

During a period of soaring budget deficits, we are certain that the American people will not support unnecessary government spending which, in this case, would not produce any additional services. We submit that universal Medicare represents a false economy both for the health care system and for beleagured agency budgets, and should be rejected by this Committee.

Besides the economic considerations, however, the question of fairness to Federal employees and retirees is also important. As the representative of over 120,000 individuals who are present or former employees of the U.S. government, we can assure the Committee that our members are willing to make sacrifices along with other Americans for the economic well-being of our nation. What is difficult for our members to accept is that for the past decade they have been forced, not asked, to bear a disproportionate share of this struggle.

Attachment A to our statement details the steady erosion in Federal pay and benefits that has taken place over the last ten years. The addition of universal Medicare - as well as the other changes in Federal pay and retirement proposed by the Administration - would place yet another burden on the incomes of Federal employees and annuitants.

For example, the President's budget calls for a 5 percent cap on the annual comparability adjustment for Federal workers, well below wage gains reported in the private sector. In addition, premiums costs under the

Federal Employees Health Benefit Program have been increased by as much as 30 percent. The addition of the 1.3 percent Medicare payroll tax would virtually eliminate any hope by Federal employees that their salaries would keep pace with rising costs.

The Medicare tax would fall most heavily on those workers at the lower end of the General Schedule. Attachment B shows the impact this proposal would have on each grade level within the General Schedule. We believe that the tax is an unfair burden on all employees; nevertheless, the fact that the deduction is a flat percentage makes it disproportionately heavy on lower-paid employees. We urge the Committee to remember that approximately one-quarter of the Federal work force earns an income which the Bureau of Labor Statistics deems to be at or below the minimum budget for an urban family of four. The additional burden of a regressive tax on the income of these individuals would be a very real hardship in these troubled economic times (see attachment C).

We would also like to remind the Committee that the universal Medicare plan would bring Federal employees under a system that is part of social security. If this proposal were adopted, Congress would be taking the first step towards universal social security coverage. As you know, a special commission is currently undertaking a comprehensive study of the future of the social security system and will not issue its report until the end of the year. In view of this fact, we believe that it would be premature to implement an aspect of universal coverage before the issue has been carefully studied.

In conclusion, we dispute the Administration's claim that universal Medicare would improve the solvency of the health care system and would also rectify past inequities. Any initial infusion of funds into the system would only be cancelled by future liabilities. We therefore urge this panel to reject the universal Medicare proposal.

We again express our appreciation to the Committee for the opportunity to appear here today. Should you have any questions, we would be pleased to reply to them at this time.

ATTACHMENT A

RECENT CUTBACKS DIRECTED AGAINST FEDERAL PAY AND BENEFITS

* In six of the past 10 years, the President has failed to adjust Federal pay to comparable wages in the private sector. These pay "caps" make Federal workers the only group of employees in the country under de facto wage controls.

* The pay caps have resulted in lower retirement benefits for Federal retirees because annuities are based upon earnings during active employment.

* In 1976, Congress eliminated the one percent "add-on" to cost of living adjustments (COLA) on civil service annuities. The "add-on" had compensated for delays in granting the COLA's after the adjustment had been computed.

* In 1977, Congress adopted a social security offset for a spouse who receives an earned retirement benefit under a government plan.

* In 1980, Congress eliminated the so called "look back" provision which enabled Federal employees, who retired after a COLA had been implemented, to have this adjustment included in the computation of their initial annuity payment.

* In 1981, Congress eliminated one of the two cost of living adjustments on Federal annuities.

* In 1981, the Reagan Administration began a massive reduction-in-force resulting in thousands of Federal employees losing their jobs.

* In 1981, as the first act of his administration, President Reagan announced a retroactive hiring freeze which took promised government jobs away from hundreds of individuals.

ATTACHMENT A (Con't)

* In 1982, the Reagan Administration instituted a 16-20 percent reduction in benefits and a 30 percent increase in premiums under the Federal Employees Health Benefit Program.

ATTACHMENT B

1981 COST OF "UNIVERSAL MEDICARE"
PROPOSAL TO FEDERAL EMPLOYEES

GS-GRADE	MEDICARE TAX
2	$ 122.00
3	133.00
4	149.00
5	167.00
7	207.00
9	253.00
11	306.00
12	367.00
*13	421.00
*14	421.00
*15	421.00

* Maximum taxable earnings $32,400.00

ATTACHMENT C

ESTIMATE
IMPACT OF A 5% PAY RAISE AND MEDICARE COVERAGE ON EMPLOYEES

ASSUMPTIONS: October 1982 Pay Increase 5%
Medicare Tax 1.3% on Pay up to $35,400. (1983)
Health Benefit Premium Increase 25%
BC/BS Family High Option
Federal Taxes 3 Exemptions
State Taxes Virginia

GS-3 $10,235 to $10,747 INCREASE $ 512 NET LOSS $ 52

Increase H.B. Premiums	$ 272
" Retirement	36
" Life Ins.	0
" Federal Taxes	94
" State Taxes	22
" Medicare	140
	$ 564

GS-5 $12,854 to $13,497 INCREASE $ 643 NET GAIN $ 22

Increase H.B. Premiums	$ 272
" Retirement	45
" Life Ins.	6
" Federal Taxes	94
" State Taxes	29
" Medicare	175
	$ 621

GS-7 $15,922 to $16,718 INCREASE $ 796 NET LOSS $ 19

Increase H.B. Premiums	$ 272
" Retirement	56
" Life Ins.	6
" Federal Taxes	218
" State Taxes	46
" Medicare	217
	$ 815

GS-9 $19,477 to $20,451		INCREASE $ 974	NET GAIN $ 56
Increase	H.B. Premiums	$ 272	
"	Retirement	68	
"	Life Ins.	6	
"	Federal Taxes	250	
"	State Taxes	56	
"	Medicare	266	
		$ 918	
GS-11 $23,[illegible]66 to $24,744		INCREASE $1178	NET GAIN $137
Increase	H.B. Premiums	$ 272	
"	Retirement	82	
"	Life Ins.	6	
"	Federal Taxes	291	
"	State Taxes	68	
"	Medicare	322	
		$1041	
GS-12 $28,245 to $29,657		INCREASE $1412	NET GAIN $ 69
Increase	H.B. Premiums	$ 272	
"	Retirement	99	
"	Life Ins.	6	
"	Federal Taxes	499	
"	State Taxes	81	
"	Medidare	386	
		$1343	
GS-13 $33,586 to $35,265		INCREASE $1679	NET GAIN $145
Increase	H.B. Premiums	$ 272	
"	Retirement	118	
"	Life Ins.	12	
"	Federal Taxes	577	
"	State Taxes	97	
"	Medicare	458	
		$1534	

Senator DURENBERGER. Thank you very much.

You mentioned that medicare coverage of Federal workers would be a first step toward universal social security coverage, and that we ought to wait for this committee to report next year. The fact of the matter is, as you well know, that practically all the other studies that have been done and which will undoubtedly be replicated in one form or another in this new study, have recommended that social security be expanded to Federal employees. So the idea that we ought to wait another year for new information doesn't make a lot of sense to me.

Mr. SAMUELS. Well, we will continue to oppose the universal medicare idea.

Senator DURENBERGER. I wear a couple of hats here—one as a Finance Committee member, and one as a member of Governmental Affairs. Over in the Governmental Affairs Committee we're talking about not only cutting back on compensation to Federal employees, but cutting back on COLA's that were, at one time, a trade-off for taxability of pensions. And so for some period of time, while benefits were increasing in the private sector and for those who benefit from entitlement programs, Federal employees have seen less in the way of cash compensation either at work or retirement. This leaves us with the problem of trying to deal realistically with the problems of providing health care to the active employee as well as to the annuitant.

Having said that, I want to lay a background for my frustration with the system. You see, I would like to do something for Federal employees, annuitants, and their families in the health care area, but I keep running up against recommendations that we cut compensations back. I expect the unions and the employees to react adversely to recommendations like these that appear to be a new burden for employees.

But I think we've got to look past the surface issues at the real impact on employees and annuitants. Isn't it true that part of the reason for the problems this last year—including the large increase in premiums—is the high cost of the annuitants in the system? In your opinion, Mr. Samuels, wouldn't making medicare primary help to solve this problem?

Mr. SAMUELS. I don't believe so. I think that—we are looking into ways to provide additional coverage to retirees. A medicare C option we have looked at. We think that together the annuitants, based on their years of service in the Government, deserve that kind of protection. They have paid into the system and we don't consider them a financial drain on this system.

Senator DURENBERGER. Well, I don't either. I'm trying to deal with the realities. Maybe you don't have the information available to you. The realities are that the cost of maintaining access to health care for the annuitants is a very substantial part of the increase in the premium cost. Is that not true?

Mr. SAMUELS. That is true.

Senator DURENBERGER. And you would only disagree with the fact that making medicare primary solves the problem?

Mr. SAMUELS. That's right.

Senator DURENBERGER. If medicare was primary wouldn't that help to reduce the cost to FEHB leaving more benefit dollars available to active employees?

Mr. SAMUELS. Well, right now medicare is the primary payer in the FEHB.

Senator DURENBERGER. That is one of the things we got into last year in this committee, as you well know.

Mr. SAMUELS. Yes.

Senator DURENBERGER. And, of course, when we suggested that FEHB be primary we got an awful lot of opposition and several contrary votes on the floor of the Senate. I think all of us are searching for something that will be helpful to the Federal employees and their families. That is why I'm introducing a comprehensive Federal employees health benefits reform bill. Among other things my alternative would allow annuitants to keep the choices that they now have in the FEHBP. At age 65 they would have a choice. Either stay in FEHBP or make medicare primary. If they chose to stay in FEHBP, then medicare would help pay the premium. Annuitants would benefit from having a choice. Active employees would benefit from not having to bear the cost of paying for the health care of retired people. And health care providers would have incentives to keep a closer eye on their costs, which is good for everybody.

I would certainly appreciate your reaction to those proposals.

Mr. SAMUELS. We would be happy to work with you, Senator, and with the committee in arriving at a solution.

Senator DURENBERGER. Thank you very much for your testimony. We appreciate it very much.

Mr. SAMUELS. Thank you.

Senator DURENBERGER. I don't believe we have any other witnesses. The hearing is adjourned.

[Whereupon, at 12:20 p.m., the hearing was adjourned.]

THE ADMINISTRATION'S FISCAL YEAR 1983 BUDGET PROPOSALS

TUESDAY, MARCH 16, 1982

U.S. SENATE,
SENATE FINANCE COMMITTEE,
Washington, D.C.

The committee met, pursuant to notice, at 9:35 a.m., in room 2221, Dirksen Senate Office Building, Hon. Robert Dole (chairman) presiding.

Present: Senators Dole, Chafee, Wallop, Symms, Grassley, and Byrd.

The CHAIRMAN. This is another day in our hearing process. As I have said in other sessions, everybody's statement will certainly be made a part of the record. I am not certain how many of my colleagues will be joining me this morning as there are several other committee meetings underway. But I would appreciate it very much if you could summarize your statements since I have another commitment at 11 and want to finish all of the witnesses. Assuming no one else shows up, the hearing will end at 11.

I think we know pretty much what each witness will say, in any event, and it is not necessary to read that to me—I can read. So if you will summarize your statement, it will be made a part of the record, and we may have some time for questions.

Our first witness this morning is Hon. Malcolm Lovell, Under Secretary of Labor.

We are happy to have you here, and if you could, identify those who are accompanying you for the record.

Secretary LOVELL. All right.

STATEMENT OF HON. MALCOLM LOVELL, UNDER SECRETARY OF LABOR, U.S. DEPARTMENT OF LABOR

Secretary LOVELL. Thank you, Senator, very much.

I have James Van Erden and Robert Deslongchamps here from our Labor Department staff, and I will just briefly summarize my statement.

I would like to express my appreciation for the cooperation demonstrated by the Congress last year in putting in place phase I of the administration economic recovery program.

I would like to comment on some concerns that have been brought to my attention about the ability of the current unemployment compensation program to meet the needs of rising unemployment. Unfortunately, unemployment is high and the concern is understandable. I do believe, however, that the basic program now in place is sufficient to address the recession-induced joblessness.

We estimate that a total of 11.5 million individuals will draw a total of $23.3 billion in benefits during the current fiscal year. In fiscal 1983, 10.6 million individuals will be paid an estimated $21 billion in benefits.

In fiscal year 1982 all but a few States will trigger on 13 weeks of extended benefits, increasing benefit duration to 39 weeks in those States. In view of this flexible program now in place, we do not need nor could we support any fundamental and costly changes that are being discussed:

Reinstituting a national extended benefit trigger is unnecessary. About 46 States will trigger on this year.

A program of benefits beyond 39 weeks is unnecessary, given the present experience of the claimants exhausting regular benefits.

Any delay in the effective date of the new State extended benefit triggers enacted by Congress last year would contribute to a larger Federal deficit. Postponement of 1 year would add $1.3 billion to the 1983 deficit.

Reversing last year's reforms for unemployment compensation for ex-servicemembers would establish inequities and would cost an additional $240 million in fiscal 1983 and another $240 million in 1984.

Removing the provision enacted by the Congress last year that requires borrowing States to pay interest on loans would eliminate needed incentives for States to adopt sound financing provisions. It would worsen an already alarming insolvency problem and would add $393 million to the deficit in 1983 and $787 million in 1984.

Now, Mr. Chairman, I would like to address three proposals for this year.

One. Trade readjustment allowances [TRA].

Only 38,000 of the workers who received trade adjustment assistance from April 1975 through March 1981, or less than 3 percent, entered training, and 1.2 percent completed training. One-third of 1 percent received relocation allowances.

Under our legislative proposal, payment of cash weekly TRA payments would be eliminated for individuals not actively engaged in a training program on July 1, 1982. Those already in approved training would be permitted to finish their training under the provisions of current law and would receive TRA weekly benefits and training costs until training is completed.

Eliminating the cash weekly benefits would save $26 million for the remainder of fiscal year 1982; $108 million in 1983; and $81 million in 1984.

Two. Unemployment compensation for ex-service members [UCX].

The proposed amendment would limit eligibility for UCX to those individuals separated for such reasons as disability incurred while in the service, demobilization, or reduction in force. Those individuals involuntarily discharged under honorable conditions but whom the military does not wish to retain would not be eligible for unemployment compensation.

Three. Round unemployment compensation weekly benefit amounts to the lower whole dollar amount.

As part of the general reform of Federal entitlement programs, this legislation would amend the Federal Unemployment Tax Act to require that State unemployment compensation laws provide, in any case where the individual's weekly benefit amount is not a full dollar, the rounding down of that amount to the closest whole dollar.

This proposal would apply to individuals whose benefit years began after June 25, 1983.

That completes my statement, Mr. Chairman. I would be glad to answer any questions.

[The prepared statement follows:]

STATEMENT OF MALCOLM R. LOVELL, JR.
UNDER SECRETARY OF LABOR
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

March 16, 1982

Mr. Chairman and Members of the Committee:

I am happy to appear before you today to discuss additional reforms we are recommending in the unemployment compensation and trade adjustment assistance components of the President's Economic Recovery Program. These recommendations will build on the reforms initiated last year in the Omnibus Budget Reconciliation Act of 1981.

The basic purposes of the 1981 amendments were two-fold: (1) to improve the equitable relationships between claimants for regular unemployment compensation and individuals receiving extended benefits, trade adjustment assistance, and unemployment compensation for ex-servicemembers, and (2) to make such economies as could be accomplished while continuing to ensure that benefits are directed to those for whom the law was intended.

As we engage in a dialogue on these important unemployment compensation issues, it is important to keep in mind the four policy fundamentals of the Administration's Economic Recovery plan:

1. Lower tax rates to stimulate savings, investment, work incentives, and productivity.
2. Control the growth of Federal spending, borrowing, and credit.
3. Decrease excessive and unnecessary Federal regulations.
4. Reduce inflation through a steady and moderate growth in the money supply.

Cooperation with Congress and with the independent Federal Reserve Board is essential to the long-term implementation of these fundamentals. In this regard, I would like to express my appreciation for the cooperation demonstrated by the Congress last year in putting in place Phase I of our Recovery program. Reforms contained in the Economic Recovery Tax Act and the Omnibus Budget Reconciliation Act were a necessary first step in implementing these policy fundamentals.

Within these broad policies it is also appropriate for me to reemphasize this year several themes that guide the Administration's approach to reforming entitlement programs:

- Remove disincentives to work and introduce incentives where possible.
- Eliminate inequitable treatment of people in similar circumstances.

- Reduce unintended and excessive benefits to recipients.
- Target benefits to those most in need.
- Improve efficient and effective management of program operations.

It is within this policy context that we are proposing three additional reforms affecting unemployment compensation and trade adjustment assistance for workers.

Before describing these proposals, I would like to comment on some concerns that have been brought to my attention about the ability of the current unemployment compensation program to meet the needs of rising unemployment. Unfortunately, unemployment is high, and the concern is understandable. However, I believe the basic program now in place is sufficient to address recession-induced joblessness.

Please keep in mind that the Budget estimates that a total of 11.5 million individuals will draw a total of $23.3 billion in benefits during the current fiscal year. In FY 1983, 10.6 million individuals will be paid $21.0 billion in benefits, at an average weekly amount of $113.

In FY 1982, all but a few States will trigger on 13 weeks of extended benefits, increasing benefit duration to 39 weeks in those States. In FY 1983, we estimate that 22 states will be paying extended benefits.

In view of this large and flexible program now in place, Mr. Chairman, we do not need nor could we support any fundamental and costly changes that are being discussed.

- Reinstituting a national extended benefit trigger is unnecessary. About 46 States will trigger on this year, targeting the additional benefits to high unemployment States where and when they are needed.
- A program of benefits beyond 39 weeks is unnecessary, given the path of the recovery that we see and given the present experience with claimants exhausting regular benefits.
- Any delay in the effective date of new State extended benefit triggers enacted by the Congress last year would be unwise, and would contribute to a larger Federal deficit. Postponement of one year would add $1.3 billion to the FY 1983 deficit.
- Reversing last year's reforms for unemployment compensation for ex-servicemembers (UCX) would reestablish inequities, re-institute incentives

for people to leave the Armed Forces, and would cost an additional $240 million in FY 1983 and $240 million in FY 1984.

- Removing the provision enacted by the Congress last year that requires borrowing States to pay interest on loans would eliminate needed incentives for States to adopt sound financing provisions in their State laws, would create additional incentives for States to borrow from general revenues, would worsen an already alarming insolvency problem in many State trust funds, and would add $625 million to the deficit in FY 1983 and approximately $1.06 billion in FY 1984.

Now, Mr. Chairman, I would like to address three proposals for this year.

1. Trade Readjustment Allowances (TRA)

The Trade Act of 1974 provided adjustment assistance in the form of reemployment services, training, job search and relocation allowances and for trade readjustment allowances (cash benefits) to workers whose unemployment is linked to increased imports of foreign made products. Our analysis of the program indicated that most workers eligible for trade adjustment assistance utilized only the cash benefits and made little use of the training or other adjustment benefits available to them. Of almost 1.3 million workers who received trade adjustment allowances (TAA) from April 1975 through March 1981, only 38,000, or less that 3 percent, entered training and 1.2 percent completed training; one-third of one percent received relocation allowances. Thus, the TAA has become primarily an income maintenance rathe than an adjustment assistance program. This led to our proposals which were contained in the Omnibus Budget Reconciliation Act of 1981. These proposals represented a fundamental shift, back to the original purposes of the Trade Act of 1974. Major emphasis is given to employment services, training, and job search and relocation services rather than income maintenance.

To summarize, the problem with the old TAA program was that TRA in the form of cash benefits provided incentives for prolonging the duration of unemployment. In contrast, last year's proposed changes provide incentives and assistance for unemployed workers to actively search for a new job. Thus, the TAA program will work to reduce, rather than increase, the unemployment in some industries.

We propose additional steps in this direction. Funds for adjustment assistance were raised to $25 million for the 1982 fiscal year. These funds will provide unemployed workers in 46 states with training, job search and relocation services. This level of funding is 3 times higher than funding levels in the last two years.

Under our legislative proposals, payment of cash weekly TRA payments would be eliminated for individuals not actively engaged in a training program on July 1, 1982. Those already in approved training would be permitted to finish their training under the provisions of current law, and would receive TRA weekly benefits and training costs during their remaining periods of eligibility.

Other training costs, and the cost of job search and relocation will continue to be paid. The Administration proposes to maintain this adjustment portion of TAA under S. 2184, the new Job Training Act of 1982. Under the bill, a Governor may use up to 10% of the funds allocated to the State to serve those who have special labor market disadvantages. This includes dislocated workers. Further, States with severe displaced worker problems may use up to an additional 5% of the allocated funds, provided that States appropriate an equal amount of matching funds to assist such workers. If essential trade adjustment assistance services are for some reason not provided under these provisions, additional funding would have to bew taken from the $200 million included in Title II-B of the Job Training Act of,1982.

Eliminating the cash weekly benefits would save $26 million for the remainder of FY 1982; $108 million in FY 1983; and $81 million in FY 1984.

2. Unemployment Compensation for Ex-Servicemembers (UCX)

One of the reforms undertaken in the Omnibus Budget Reconciliation Act of 1981 was to revise the eligibility requirements for UCX, effective for separations from the service beginning July 1, 1981, to deny payments to individuals who separated from the military under honorable conditions and who had an opportunity to reenlist. While it was not intended, this change resulted in the continuance of eligibility for individuals who were discharged under honorable conditions and whom the military does not wish to retain, such as those with a record of disciplinary infractions or who failed to maintain requisite skill proficiency.

The proposed amendment would limit eligibility for UCX to those individuals separated for such reasons as disability incurred while in the service, demobilization, or reduction in force. Those individuals involuntarily discharged under honorable conditions but whom the military does not wish to retain would not be eligible for unemployment compensation. The legislation, effective for those discharged on or after July 1, 1982, would reduce outlays by $5 million in FY 1982, and by $30 million in FY 1983.

3. Round Unemployment Compensation Weekly Benefit Amounts to the Lower Whole Dollar Amount

As part of the general reform of Federal entitlement programs, this legislation would amend the Federal Unemployment Tax Act to require that State unemployment compensation laws provide, with respect to an individual's weekly benefit amount in any case where the individual's weekly benefit amount is not a full dollar, the rounding down of that amount to the closest whole dollar amount.

The proposal would apply to individuals whose benefit years began after June 25, 1983. It is not intended that the change impact on current unemployment compensation claimants. Any loss to an individual claimant will be minimal, since with inflationary effects upon wages, the average weekly benefit amount continues to rise from year to year. Savings realized by this proposal should reduce costs by $6 million for Fiscal Year 1983.

Mr. Chairman, this completes my formal statement. We would be pleased to entertain any questions you or the Committee may have.

Thank you.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. I have no questions, Senator.

The CHAIRMAN. Mr. Lovell, I have met with some legislators, a bipartisan group from the State of Michigan, who were very concerned, because of that State's exceedingly high unemployment rate, about relaxing or repealing certain provisions of the unemployment compensation loan-reform mechanism enacted last summer. As you recall, these provisions are designed to provide incentives for States to strengthen the financial condition of their unemployment compensation programs.

Have you been contacted by these same representatives or are you aware of the problem in Michigan?

Secretary LOVELL. I am aware of the problem. I have not been contacted by them. Having come from Michigan myself, I am certainly sympathetic to the situation.

I think, however, we have to recognize that the changes that were made in the law, to encourage States to pay back moneys they owe in a reasonably prompt way and to impose interest payments if they don't, on it really do make sense over the long term for most States. To make arbitrary exceptions without due regard for all of the conditions would be wrong.

We are following and watching the situation carefully.

If it appears that changes in the law are necessary for equitable treatment of this State, we will appear before you to discuss those changes. But we do not think at this time that any such action is justified.

The CHAIRMAN. Well, I wish you would check into that for me. I do think there is certainly some merit in their request that we address it. If we can in some way balance the cost to the Federal Government of delaying the repayment of interest provisions against the impact of increased tax costs for the employers, then we need to address that fairly soon. Obviously, Michigan has been particularly hard hit, and I don't see any prospects for any immediate recovery.

Secretary LOVELL. No, that certainly is true.

The CHAIRMAN. This committee, including some of the members who aren't here this morning, Senator Bentsen and Senator Long to name two, have been actively involved in the development of the work incentive program over the years. The administration proposes to eliminate funding for the program and replace it with a new employment training program targeted at disadvantaged youth and AFDC recipients.

Do you have any sophisticated guess on how that program might work?

Secretary LOVELL. Yes.

The CHAIRMAN. Do you think it will work? I guess that's the first question.

Secretary LOVELL. I wouldn't say it was a sophisticated guess, but I have got a reasonable judgment on it.

The proposed program really is a return to the fundamentals that we know something about in the employment and training area. It emphasizes the eligibility of people on AFDC, they will be provided with on-the-job training and institutional training, basic education, labor market services. These are the kinds of things that have been done under WIN historically. I don't really regard it as eliminating WIN. I regard it as a modification of the process by which the various aspects of the program are carried out, giving the State greater flexibility to put it together.

But certainly most of the same tools are there as were under the WIN program. There is somewhat less money in the bill for some of the supportive services, but I think imaginative organization and the combining of resources within the States will be able to meet most of these needs.

The CHAIRMAN. Well, I might suggest that you or someone be in direct contact. They may want to submit some questions in writing.

Secretary LOVELL. We would be delighted.

The CHAIRMAN. Prior to that, if you would contact both Senators Long and Bentsen, they would be pleased to learn you are not talking about eliminating the program, you are talking about some other way to proceed. I think that is important. There is a lot of support for the WIN program on this committee.

I also have some questions on the trade adjustment assistance program which I will submit.

Secretary LOVELL. Fine.

[The questions follow:]

RESPONSES FOR RECORD TO QUESTIONS SUBMITTED BY SENATOR RUSSELL B. LONG

Question 1. The Administration, in proposing zero funding of WIN for fiscal 1983, has nevertheless given the impression that the program will continue to operate with State funds or by States' diverting funds to WIN from the title XX block grant. What is your best estimate of the total funding that the WIN program will receive from these sources in fiscal year 1983?

Answer. The WIN program relied on related programs (such as CETA, Title XX) to provide services which support work involvement by AFDC recipients. Although the WIN program, as such, will not continue, States will continue to operate WIN-type activities. The States are being advised to continue relying on alternative sources such as the Social Services block grant and the proposed Job Training Grants to States. The most successful direct work activities such as the Community Work Experience Program (CWEP) and job search will be funded through the IV-A agencies. States will have the flexibility to direct resources to those programs and activities which will produce the greatest return on the dollar expended.

Question 2. If the Administration anticipates that States will in fact continue to operate the WIN program, there would seem to be no reason to withhold current year program funds for "closing-down costs". Have you in any way encouraged or directed either your regional offices or the States to set aside a portion of the present-year appropriation for such costs? Please detail any actions of this nature that have been taken.

Answer. While States may continue WIN-type activities under other legislative authorities and funding sources, they will have to close-out their WIN grants. Close-out costs will therefore be incurred. Thus, it is only prudent management to reserve funds for that eventuality. Accordingly, the Department of Labor (DOL) is instructing States to reserve sufficient funds from their fiscal 1982 allocations to cover those close-out costs. In addition, the Office of Family Assistance (OFA), Department of Health and Human Services (DHHS), published on March 11, 1982, an AFDC Action Transmittal which specifies the conditions under which funds may be transferred at the Governor's request from either the regular WIN program or the WIN Demonstration Program.

Question 3. Assuming that States do not choose to substitute their funds to keep WIN in operation, how do you plan to comply with the substantive requirement of present law (section 402(a)(19)(A) of the Social Security Act) that all employable AFDC applicants must register with the Secretary of Labor for manpower services, training, employment, and other employment-related activities? Specifically, will this equirement be carried out by State employment service agencies or do you intend to mandate that it be carried out by the agencies administering the new employment program embodied in S. 2184?

Question 4. The Social Security Act also gives the Secretary of Labor responsibility for an enforcement function with respect to the acceptance of employment (section 402(a)(19)(f) of Social Security Act). Please indicate how you will be carrying out this responsibility in the absence of a WIN agency?

Answer. The specifics of how a work requirement will be administered under the Administration's new proposals in this area are now being developed by the Office of Family Assistance. DHHS, and the Employment and Training Administration, DOL.

Question 5. What was the cost in the most recent fiscal year of carrying out the registration and work requirement enforcement functions discussed in the last two questions? How much have you budgeted for continuing these functions in the absence of the WIN program? If these functions are to be carried out as a part of the Administration's proposed employment and training program, will these costs be considered administrative costs subject to the 10 percent limit on administration?

Answer. In fiscal 1981, approximately one-fourth (or $86.4 million) of the total WIN expenditure was utilized for the administration of the mandatory registration and work requirement functions. No specific amounts are budgeted for these functions in fiscal 1983. Whatever registration and employment assessments are necessary to participate in work activities (e.g. CWEP and job search) will be paid out of Social Security Act Title IV-A funds.

Question 6. According to statistics provided by the Department of Labor, the WIN program in fiscal year 1981 registered 1.2 million employable welfare recipients and placed some 300 thousand recipients in jobs. The Department computed the annualized welfare grant reductions for the year at $760 million compared with $365 million in program costs. Please provide an estimate of the AFDC recipients who will be registered and who will be placed in employment in fiscal year 1983 under the Administration's proposed employment and training legislation. Please also indicate the amount of funds under that program which you estimate will in fact be spent on AFDC recipients and the savings in AFDC costs that you project as a result.

Answer. The eligible population is 3.4 million AFDC recipients nationwide. Each Private Industry Council will serve AFDC recipients in its Service Delivery Area based on local circumstances. It is difficult to make a valid estimate of costs or reductions in cash welfare payments at this point because States will have an array of resources from which to draw. For example, some States will operate Community Work Experience Programs or combine Social Services funds with Job Training funds to provide supportive services. In any event, we cannot compare WIN with the proposed block grant approach since WIN is a structure program with definite eligibility criteria, two funding sources, an adjudication process, and a specific formula for determining annualized welfare grant reductions. Under the block grant concept, each area will have the flexibility it needs to direct its funds and services to address the most urgent local needs.

Question 7. In the past, employment and training programs (other than WIN) have tended not to serve a large proportion of AFDC recipients. The Administration's new proposed program would make AFDC recipients one of two basic eligibility groups, but the legislation does not otherwise mandate that the funds actually be directed at AFDC recipients. Would the Department of Labor be willing to accept an amendment which specified that a minimum percentage of program funds be used to serve AFDC recipients? If so, what percentage would you consider acceptable?

Answer. The Administration intends that members of families who are AFDC recipients be served in significant number under its proposed legislation. The Administration bill did not propose a specific set-aside to serve AFDC recipients. However, if one were to be used, we think it should be in proportion to the percentage of this eligible population in the service area.

RESPONSE FOR RECORD TO QUESTIONS SUBMITTED BY SENATOR LLOYD BENTSEN

WORK INCENTIVE PROGRAM (WIN)

Question 1. Does the Administration plan to establish some quantitative criteria for evaluating its new Job Training Program (as proposed in S. 2184)? Specifically, will a given percentage of funding and/or clients have to be welfare recipients under the AFDC program?

Answer. Yes, we do plan to establish quantitative criteria for evaluating the new Job Training Program. The Administration bill did not propose a specific set-aside to serve AFDC recipients. However, if one were to be used, we think it should be in proportion to the percentage of this eligible population in the service area.

Question 2. How will the Administration determine that its intention to target AFDC recipients for job training and placement has been met?

Answer. The Private Industry Council (PIC) for each Service Delivery Area will prepare a program plan to serve the AFDC population in its area. PIC plans will be reviewed by the State Job Training Councils, and the Governors will have overall responsibility for assuring that plans meet the purposes of the Act. Performance would then be measured against the plan and against performance standards established by the State. Such performance standards must be consistent with performance standards established by the Secretary, which are planned to include a measurement of welfare savings.

Question 3. If the Administration does not establish performance based criteria for measuring the effectiveness of its Job Training Program on the AFDC population, will the Secretary ask Congress to do away with the statutory requirement that AFDC recipients be assisted in finding employment?

Answer. The Administration does plan to establish performance standards. Plans include using a factor to measure welfare savings. The Administration has no intention of doing away with a requirement that AFDC applicants and recipients be assisted in finding employment.

Question 4. Will the Administration seek federal funding for the Community Work Experience Program? And will AFDC recipient participation in CWEP be monitored against established performance standards? If CWEP is not federally funded, will the States be required to comply with the statutory provision regarding placement of AFDC recipients in employment?

Answer. The State welfare agency administrative expenditures for the proposed Community Work Experience Program (CWEP) are authorized under Title IV-A of the Social Security Act, in which the Federal government matches State expenditures on a 50-50 basis. There are to be no Federally-mandated performance standards in CWEP; States will set their own. CWEP will provide work experience which will assist CWEP participants to qualify for work.

TITLE V OF THE OLDER AMERICANS ACT, SENIOR COMMUNITY SERVICES EMPLOYMENT PROGRAM (SCEP)

Question 1. Does the Administration intend to earmark Job Training Program funds or Employment and Training funds under the State block grant proposal for part-time employment of the elderly?

Question 2. If so, what proportion of funds will be set aside to continue these programs? By comparison with previous years (1980 and 1981), how many job slots will the fiscal year 1983 budget accommodate?

Question 3. If not, will alternative employment programs for the elderly be established? Please describe including anticipated authorization level, number of positions, criteria for participation, type of employment.

Answer. We can assure you the Department is continuing to examine for fiscal year 1983 additional ways of meeting the employment and income requirements of the elderly in a responsible fashion. We regret that we are not able to give the Committee a more definitive response at this time, but we are examining the various options available and weighing the human concerns for the elderly population with the overall demands placed on all of us for fiscal restraint.

Question 4. In conjunction with reauthorization of the Older Americans Act last year, the Congress approved an amendment calling for DOL to establish demonstration programs to better place Title V participants in private sector positions. Has DOL developed its plan to implement such pilot projects? What is the status of DOL's efforts to comply with that provision?

Answer. Under Public Law 97-92, the Continuing Appropriation Resolution, in which forward funding for the SCSEP was deleted by the Senate Committee action, there were no funds available to implement private sector demonstration projects. Therefore, the Department has not developed criteria for the award of such projects.

The CHAIRMAN. Again, interest in that program has been expressed by Senators Danforth and Moynihan. I think the questions we have prepared would address their interests.

We did appropriate money last year, as you know and you did mention in your statement.

On another unemployment issue, we are being advised that some Members of Congress have introduced legislation to repeal the provision tightening unemployment compensation for ex-servicemen enacted last year. Now the administration is suggesting further restrictions. I guess the question is whether or not this is having any impact on enlistments in the Armed Forces. I can't see that it would, but maybe it does.

Secretary LOVELL. Well, I don't think it would. Obviously the provision was originally enacted when we had a draft, when people went into the Armed Forces predominately under those conditions rather than under the volunteer conditions that exist today. Regarding it in that fashion there is no reason why individuals choose not to re-enlist, should be eligible for unemployment compensation.

The amendments that we are suggesting are really equity adjustments so that those people who are perhaps even less deserving than those who decide not to reenlist, namely, those who for one reason or another are not deemed to be satisfactory—they are not dishonorably discharged but they are involuntary discharged for other causes—would also not be eligible for unemployment compensation. That is why that provision is being suggested.

The CHAIRMAN. The Secretary of Labor recently announced the administration's intent to support an expansion of the targeted jobs tax credit. Do you have any specifics on that that you might furnish us for the record?

Secretary LOVELL. Well, I think we perhaps were negligent in not advising this committee of that judgment area, Senator, and we do apologize for that. We will be glad to give you a report on it in writing.

[The information follows:]

As you know, the Secretary on March 15th announced that the Administration will be proposing an extension of the Targeted Jobs Tax Credit (TJTC) legislation. The specifics of the proposal are still under consideration, and we will be pleased to share them with the Committee at the earliest possible date.

The CHAIRMAN. Some of us, though we have supported the targeted jobs tax credit, have done it without much enthusiasm on the theory that it was primarily for fast-food operations and didn't really do much as far as meaningful employment for anyone, particularly young people.

Secretary LOVELL. Well, it's one of these things.

The CHAIRMAN. Maybe you have some better ideas.

Secretary LOVELL. Well, it's got a lot of potential, and I don't think the potential has been fully realized in our past efforts.

Senator CHAFEE. Mr. Lovell, I missed the discussion that Senator Dole, the Chairman, was directing to you regarding a Michigan problem. What is that? Because whatever problem they have got I believe we well might have.

Secretary LOVELL. Well that is one of the problems, it is not unique to any one State. I think perhaps it is a little more of a problem in Michigan.

The basic question is whether the requirements which come into effect on April 1, in which interest is to be paid on the loan balances that have been borrowed from the Federal Treasury to pay unemployment compensation, should be postponed or delayed.

Senator CHAFEE. I think the changes we made last year that if they had to go back into their borrowing and they weren't able to repay that additional amount within a year, then they——

Secretary LOVELL. They have to pay interest on it.

Senator **CHAFEE** [continuing]. Then they pay interest.

Secretary **LOVELL**. Yes, at a maximum rate of 10 percent.

Senator **CHAFEE**. Which they don't do now.

Secretary **LOVELL**. That's right. And that's to encourage States to bring their tax rate and their benefit rate more in line with their needs, so that the general taxpayer is not financing the State programs disproportionately.

Senator **CHAFEE**. I see. All right; thank you.

The **CHAIRMAN**. There will be other questions in writing, and I would appreciate it if you would give me a report not only on Michigan but other States that may be in the same predicament.

Secretary **LOVELL**. A new requirement relating to States with loans was included in the provisions of the Omnibus Budget Reconciliation Act of 1981. If a new loan is made after March 31, 1982, and is not repaid in the same fiscal year in which it is received (by September 30), the State will be required to pay interest, at a maximum rate of 10 percent, not later than the first day of the new fiscal year, October 1. Unlike the so-called "penalty" tax, which employers in a State with unpaid loans now are required to pay, and which is credited to the State's outstanding indebtedness, the payment of interest is made to the U.S. Treasury and is not credited to the State Trust Fund. A further requirement is that the moneys to pay the interest may not be drawn from the State unemployment fund but must be provided from some other source. If a State does make payment of interest from its unemployment fund, the Secretary of Labor is prohibited from certifying the State unemployment compensation law for offset credit against the Federal Unemployment Tax Act (FUTA). Employers in any such State would thus be required to pay a tax of 3.4 percent to the U.S. Treasury and still be liable to pay their State unemployment compensation tax as levied under the particular State law. Additionally, if the State unemployment compensation law is not certified by the Secretary of Labor for tax credit, the State is also not eligible to receive Federal grants for costs of administering the unemployment compensation law and the State employment service.

In addition to Michigan, our present estimates are that loans will be made between April 1 and September 30 of 1982 to the following States:

Arkansas, Delaware, Illinois, Iowa, Kentucky, Minnesota, Missouri, New Jersey, Ohio, Pennsylvania, West Virginia, and Wisconsin.

The **CHAIRMAN**. Thank you very much.

[The questions follow:]

RESPONSE FOR RECORD TO QUESTIONS SUBMITTED BY SENATOR LLOYD BENTSEN

Question 1. What training (or "retraining") alternatives will be available to a worker displaced by imports after July 1982 when, under the Administration program, the Trade Adjustment Assistance program expires?

Answer. The Administration's Bill does not purport to terminate the Trade Adjustment Assistance (TAA) Program effective July 1982. The Administration's proposal is merely to phase out the cash benefits portion of the program by restricting Trade Readjustment Allowances (TRA) to those workers enrolled in training as of July 1, 1982. Training, job search and relocation allowances would continue to be provided to eligible workers through September 30, 1983, when the program is scheduled to expire.

Our proposed elimination of the TRA cash benefits is consistent with our belief that the regular UI program with its extended benefits (EB) protection during periods of high unemployment is an adequate wage loss compensation program for unemployed American workers. The long range goal of this proposal is to have TAA certifications occur within the statutory 60-day period and to have workers enter approved training while they are still in a perod of UI or EB eligiblity.

Question 2. How does the Administration plan to deal with the increasing disparity in training (and the consequent ability to adjust) of workers in countries directly in competition with the United States, such as those in Japan, Germany, and France?

Answer. As you may know, the General Accounting Office (GAO) visited seven of our trading partners—Australia, Canada, France, Japan, Sweden, The United Kingdom, and West Germany—in 1978 to determine which program techniques used in these countries would be of interest in modifying the U.S. Trade Program. The GAO reported in its January 18, 1979, report that other countries, for the most part, provide assistance through existing programs rather than establishing special assistance programs. Finally, GAO concluded that before any of the approaches identified in its report are considered for use in the United States, further analysis should be made to determine their feasibility and cost.

Any approach to addressing the above question must be made within the context of the Administration's overall trade policy with a goal of strengthening the U.S. economy through free trade as well as the feasibility and cost of establishing such special assistance. Inherent in the Administration's trade policy is the premise that these matters are best dealt with in the international competitive markets.

Secretary LOVELL. Thank you very much.

The CHAIRMAN. Unless there is some objection, I wonder if we might make one minor adjustment in the hearing schedule, if we might have Jan Deering, Marian Edelman and Joyce Black.

Are you all here? We will move you ahead of the next panel listed.

Senator CHAFEE. I don't think Ms. Edelman is here, is she?

Ms. HOFFMAN. Ms. Edelman is sick, and I will fill in for her.

Senator CHAFEE. Oh, you are going to pinch-hit for her. OK.

The CHAIRMAN. I think Senator Chafee has to be at another session soon. We will do it this way.

Is that all right with you fellows? [Laughter.]

The record will note that it is all right.

As I have indicated, your statements will be made a part of the record, and we would hope you might summarize. This is one of those days where we have to be in about three places at once.

Jan, do you want to start?

STATEMENT OF MS. JAN DEERING, PUBLIC POLICY CHAIRMAN, ASSOCIATION OF JUNIOR LEAGUES, NEW YORK, N.Y.

Ms. DEERING. Good morning. I am Jan Deering. Contrary to the agenda, I am from Wichita, Kans., not New York. The Association's headquarters is in New York.

Senator CHAFEE. That gives you a headstart with this committee, if you are from Wichita, Kans. [Laughter.]

Ms. DEERING. I am the public policy chairman for the Association of Junior Leagues, which is an international women's volunteer organization with 240 member leagues in the United States representing approximately 142,000 members.

I really appreciate this opportunity to appear before you today to express the Association's concern about the devastating effect that we believe President Reagan's most recent budget proposals will have on some of our Nation's neediest children and families.

A little less than 1 year ago today I appeared before this committee to urge you to preserve the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). Fortunately for our Nation's neediest children, Congress did respond to the pleas of child advocates to save this landmark legislation and refused to place it in a social services block grant, as requested by the President.

I now appeal to you to reject President Reagan's most recent proposal to place child welfare services, foster care, adoption assistance and child welfare training into a child welfare block grant.

The President's budget proposes an authorization of $380 million for the new block grant for fiscal year 1983, a cut of at least 23 percent below the amount the administration estimates these programs will cost during this fiscal year and 46 percent below the funding levels originally expected for these programs for fiscal year 1983 when Public Law 96-272 was enacted in 1980.

We also are urging you to reject further cuts in the Title XX Social Services Block Grant and the Maternal and Child Health Block Grant.

But today I would like to use my time to relate what the passage of Public Law 96-272 has meant to Kansas and what the cuts in social services have meant to the working poor in our State, because my written testimony will illustrate what is happening in States all over the country.

Last year when I testified before you I mentioned that the subsidized adoption program in Kansas had temporarily run out of funds. Consequently, at the time I testified, 10 children for whom adoptive families had been approved had had to remain in foster care because there were no funds for subsidy. This type of situation will not arise again in any State if the adoption assistance program authorized by Public Law 96-272 is allowed to continue as an entitlement.

For the first time, as a result of a permanency-planning project initiated by the Kansas SRS, detailed statistics are available on the children in out-of-home placement in my State.

So, according to a report issued by SRS in November 1981, 5,914 children were in some form of out-of-home placement as of June 30, 1981. Two hundred and six of these children had been in nine or more placements. Almost 1,500 of them had been in care for more than 3 years. Slightly more than 450 of these children had been in care for more than 8 years. Furthermore, the case plan for 68 of the children who were in foster care for 6 years or more still read, "return to parents." Significantly, though, despite the inauguration of the permanency-planning project in Kansas, case plans still have not been developed for more than over 500 of the children in out-of-home care.

To comply with the requirements of Public Law 96-272, Kansas is moving toward the establishment of a judicial review system for children in out-of-home care. Legislation mandating judicial review has passed the Kansas State Senate and is awaiting approval by the House of Representatives. And the three Junior Leagues in Kansas, working through their Public Affairs Committee, strongly support this legislation.

Experiences with foster care review systems in other States indicate that regular reviews such as those mandated by Public Law

96-272 result in achievement of permanency for children either by reuniting their families or, when this isn't possible, terminating parental rights, freeing the child for adoption.

We also believe that it is imperative that Congress not make any further cuts in the Title XX Social Services Block Grant, the major funding program for social services in this country. We already know that the cuts have eliminated many vital programs, especially those for the working poor. In Kansas, for example, the Department of Social and Rehabilitative Services has reduced the day care slots it funds in the Wichita area from 800 to 280 and reduced its eligibility level for Title XX day care from 64.3 percent to 55 percent of the State's median income.

According to most observers in Kansas, parents who have lost day care for their children are trying to maintain their jobs by making unsatisfactory or makeshift child-care arrangements, placing their children in unlicensed homes or leaving them alone.

I concur with the director of the Child Care Association of Wichita's assessment that withdrawing financial assistance to working parents is not really saving tax dollars.

The difficulties the poor, especially the working poor, are having in obtaining appropriate child care will be further exacerbated if Congress accepts President Reagan's proposal to eliminate funding for the WIN program.

In conclusion, I urge you to continue to safeguard the health and lives of our Nation's neediest women and children by providing adequate funding for the programs that serve them and preserving Public Law 96-272.

Thank you again for this opportunity to appear before you.

PREPARED STATEMENT OF THE ASSOCIATION OF JUNIOR LEAGUES, INC., BY JAN DEERING, PUBLIC POLICY CHAIRMAN

I am Jan Deering of Wichita Kansas, Public Policy Chairman of the Association of Junior Leagues. The Association of Junior Leagues is an international women's volunteer organization with 240 member Leagues in the United States, representing approximately 142,000 individual members. Junior Leagues promote the solution of community problems through voluntary citizen involvement, and train their members to be effective voluntary participants in their communities. The Association's commitment to the improvement of services for children is long-standing. Junior League volunteers have been providing services to children since the first Junior League was founded in New York City in 1901. In the 1970's, the Association and individual Junior Leagues expanded their activities on behalf of children to advocate for legislation and administrative changes directed at improving the systems and institutions which provide services to children and their families.

I appreciate this opportunity to appear before you today to express the Association's concern about the devastating effect that we believe President Reagan's most recent budget proposals would have on some of our nation's neediest children and families. A little less than a year ago today, I appeared before this committee to urge you to preserve the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). Fortunately for our nation's children, Congress responded to the pleas of child advocates to save this landmark legislation and refused to place it in a Social Services Block Grant as requested by President Reagan.

I now appeal to you to reject President Reagan's most recent proposal--to place child welfare services (Title IV-B of the Social Security Act), foster care, adoption assistance and child welfare training into a Child Welfare Block Grant. The President's budget proposes an authorization of $380 million for the new block grant for Fiscal Year 1983, a cut of at least 23 percent below the amount the Administration estimates these programs will cost during this fiscal year and 46 percent below the funding levels originally expected for these programs for Fiscal Year 1983 when P.L. 96-272 was enacted in 1980. We also urge you to reject further cuts in the Title XX Social Services Block Grant and the Maternal and Child Health Block Grant. I would like to touch briefly on the Association's reasons for making these requests.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272)

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) was passed in 1980 with strong bipartisan support after almost five years of effort by child advocates--inside and outside of Congress--on behalf of the reforms embodied in P.L. 96-272. Currently, some 500,000 children are in some type of foster care in this country. The Adoption Assistance and Child Welfare Act of 1980 was designed to reform this country's child welfare system by providing fiscal incentives for states to redirect their child welfare services from out-of-home care to provide services to help families stay together as well as services to reunify families that have been separated. When reunification is not possible, the procedural reforms mandated by P.L. 96-272 encourage the termination of parental ties and moving the child out of foster care into a permanent adoptive home. P.L. 96-272 mandates procedural reforms such as the development of case plans, case reviews, including a dispositional hearing after a child is in care 18 months, and inventories of children in foster care, and establishes a subsidized adoption program for children with special needs--mental, physical or emotional handicaps.

Demonstration projects across the country have shown that the reforms mandated by P.L. 96-272 are cost-effective and long-lasting. For instance, in California, the results of two demonstration projects established by the state's Family Protection Act proved that admissions to out-of-home placement drop when services such as counseling, homemaker service and respite care are provided to troubled families.

Representatives of the San Francisco and Palo Alto Junior Leagues, two of the eight Junior Leagues in California that supported passage of the Family Protection Act, served on the FPA Evaluation Committee of the San Mateo County Department of Health and Welfare's Family and Children's Services Advisory Committee. The effects of the demonstration project were dramatic in San Mateo County. There was a 33 percent decrease in the admissions to foster homes and institutions in the three-year period from September 1977 to September 1980. This significant drop came at a time when the reduction in out-of-home placements statewide was only one percent. Most importantly, in 1975, before the project was initiated, 47 percent of the children placed out-of-home that year were still in placement two years later.

The Child Welfare Block Grant proposed by President Reagan would effectively destroy P.L. 96-272 by eliminating all fiscal incentives for states to institute the reforms it mandates. The proposed Child Welfare Block Grant also would eliminate the entitlement nature of both foster care and the adoption assistance program. P.L. 96-272 does not allow a cap to be placed on foster-care funding until a certain amount of money has first been appropriated under Title IV-B to provide for preventive and reunification services. To cap foster care without first providing funding for preventive and reunification services, could lead to situations endangering the lives of children. The entitlement status of the adoption assistance program assures states that funds will be available on a long-term basis for the subsidies needed to provide adoptive homes for special needs children.

Last year when I testified before you, I mentioned that the subsidized adoption program in Kansas had temporarily run out of funds. Consequently, at the time I testified, ten children for whom adoptive families had been approved had to remain in foster care because there were no funds for subsidy. This type of situation will not arise again in any state if the adoption assistance program authorized by P.L. 96-272 is allowed to continue as an entitlement.

For the first time, as a result of a permanency-planning project initiated by the Kansas Department of Social and Rehabilitative Services (SRS) in 1980, detailed statistics are available on the children in out-of-home placement in my state.

According to a report issued by SRS in November 1981, 5,914 children were in some form of out-of-home placement as of June 30, 1981. Two hundred and six of these children had been in nine or more placements. Almost 1,500 of them had been in care for more than three years. Slightly more than 450 of these children had been in care for more than eight years. Furthermore, the case plan for 68 of the children who were in foster care for six years or more still read, "return to parents." Significantly, despite the inauguration of the permanency-planning project in Kansas, case plans still have not been developed to date for more than 500 of the children in out-of-home care.

To comply with the requirements of P.L. 96-272, Kansas is moving toward the establishment of a judicial review system for children in out-of-home care. Legislation mandating judicial review has passed the Kansas State Senate and is awaiting approval by the State House of

Representatives. The three Junior Leagues in Kansas, working through their Kansas State Public Affairs Committee (SPAC), strongly support this legislation.

Experiences with foster care review systems in other states indicate that regular reviews such as those mandated by P.L. 96-272 result in achievement of permanency for children either by reuniting families or, when this is not possible, terminating parental rights, freeing the child for adoption. We are certain that many of those children who have been in foster care for the past eight years in Kansas would have permanent homes today if P.L. 96-272 had been enacted earlier. In fact, caseworkers with whom I spoke mentioned a "stagnant population that was passed over ten years ago." As you are aware, expenditures of monies directed toward programs which prevent children from entering foster care and those which enable children to move from the foster care system into permanent adoptive homes are cost-effective. In Kansas, the adoption support program is one of the most cost-effective programs we have due to its ability to reduce the number of children who might be caught permanently in the foster care system.

Kansas is not the only state that is changing its laws to meet the mandates of P.L. 96-272. Missouri Governor Christopher Bond has developed an Initiatives for Children program in response to P.L. 96-272. The initiative is designed to:

- reduce the number of abused or neglected children who enter foster care each month from the current level of 230 to 160 by June 1983
- return home within six months of placement 50 percent of all children entering foster care or residential treatment by June 30, 1983
- reduce the number of children in foster or residential care by seven percent--from 5,930 in October 1981 to 5,515 by June 1983
- place in adoptive homes, within twelve months of termination, 65 percent of all children whose parental rights have been terminated by June 1983
- raise Missouri's current ranking for resident infant mortality from the bottom 20 states to the top 20

- reduce the percentage of Missouri women receiving inadequate prenatal care from 17.9 percent in 1980 to below 14 percent in 1984.

The Junior League of St. Louis strongly supports the Initiatives for Children program. On January 25, the President of the Junior League of St. Louis wrote the members of the Missouri Congressional delegation that:

> Missouri legislators have taken advantage of these mandates [P.L. 96-272] by submitting several bills which would enact these policies in our state. Any attempt to further cut federal incentives would seriously hamper Missouri's efforts. We are dealing with programmatic concerns and funding...earmarked for the growing problems affecting children. We believe children deserve special mention in social service funding. There is growing attention given to keeping families intact and giving each child the opportunity to have a permanent, nurturing home.

The amount requested by President Reagan for the Child Welfare Block Grant for the next fiscal year is only slightly less than the amount that is projected to be spent on foster care alone in Fiscal Year 1983. States already hard-pressed to fund existing needed programs will have little incentive to develop new programs. Nor will they be encouraged to establish subsidized adoption programs which require long-term financial commitments to adoptive families--even though these programs eventually will save thousands of dollars in foster care payments and, most importantly, provide some of this nation's neediest children with permanent homes.

States are unlikely to begin to change old patterns of behavior unless they can be certain that some type of fiscal help will be forthcoming from the federal government. As a delegate from the Junior League of Wilmington, Delaware reported when she appeared before the House Ways and Means Committee's Subcommittee on Public Assistance and Unemployment Compensation in support of H.R. 3434 (the bill that became P.L. 96-272) two years ago:

> Lobbying experience with Delaware's General Assembly has taught us that our state legislators look first to the

> federal government for procedural guidelines and availability of funds in deciding the validity of proposed legislative reforms...
>
> We need these procedural reforms to alleviate foster care 'drift', to stop unnecessary and inappropriate placements, and to end the unnecessary years spent in care by hundreds of thousands of foster children.
>
> We need federal fiscal incentives for states to provide reunification-of-family services, programs emphasizing prevention rather than crisis intervention, review and tracking systems, and adoption subsidies.

Congress showed its determination to save P.L. 96-272 by refusing to place Title IV-B, foster care and adoption assistance, in a Social Services Block Grant during its last session. We urge you now to reject the President's most recent proposal to place these programs in a Child Welfare Block Grant and to reject any further cuts in the funding for Title IV-B.

Title XX Social Services Block Grant

We also believe that it is imperative that Congress not make any further cuts in the Title XX Social Services Block Grant, the major federal funding program for social services in this country. Many of the core services needed to help families, such as protective services, homemaker service, day care and respite care are funded by Title XX. The implementation of the reforms mandated by P.L. 96-272 depends on support services such as those funded by Title XX.

The Omnibus Budget Reconciliation Act of 1981 placed Title XX of the Social Security Act in the Social Services Block Grant along with Title XX training and social services monies for the territories. Funding for the Social Services Block Grant was set at $2.4 billion, a cut of 23 percent from the almost $3.1 billion funding set by P.L. 96-272 for Fiscal Year 1982 for the programs included in the block grant.

Now, President Reagan has requested that the Social Services Block Grant be cut back to $1.9 billion in Fiscal Year 1983, more than 500 million dollars below the $2.45 billion established for it for Fiscal Year 1983 by the

Omnibus Budget Reconciliation Act. We believe that such a large cut coming directly on the heels of the substantial cut made for this fiscal year will throw social services programs across the nation into chaos. It is still too early in many cases to determine the type and extent of the effects of this year's cuts. For this reason, we believe that it would be unwise to make any further cuts until more information is available about the effect this year's cuts are having on social services.

We already know, however, that the cuts have eliminated many vital programs, especially those for the working poor. In Kansas, for example, the Department of Social and Rehabilitative Services (SRS) has reduced the day care slots it funds in the Wichita area from 800 to 280 and reduced its eligibility level for Title XX day care from 64.3 percent to 55 percent of the state's median income. SRS also has shifted all of its AFDC recipients out of Title XX day care, requiring that they pay for child care with the child-care deduction allowed under AFDC. According to most observers in Kansas, parents who have lost day care for their children are trying to maintain their jobs by making unsatisfactory or makeshift child-care arrangements, placing their children in unlicensed homes or leaving them alone. A survey made of the 492 working families in Sedgwick County that were eliminated from the subsidized child-care programs found that only 20 of these families are using the child-care deduction. Because of the new AFDC requirement for retrospective budgeting, families will have to wait two months to receive reimbursement for their child-care expenses. Very few families making the minimum wage can advance the two months payment required before the child-care deduction becomes available. Moreover, the child care that parents are able to purchase with the $160 child-care deduction often is not of the quality provided in a Title XX Center.

I concur with the Director of the Wichita Child Day Care Association, an organization that has received financial support from the Junior League of Wichita, that we are not really saving tax dollars by withdrawing financial assistance for working parents. In addition to caring for children, good child care also provides a positive setting and satisfactory role model for children that can produce long-ranging beneficial results.

A similar situation regarding child care exists in other parts of the country. In Pennsylvania, for instance, the state government responded to the federal budget cuts by reducing the eligibility levels for subsidized child care in November, dropping the level from 115 percent to 90 percent of the state's median income, and requiring that every parent pay some fee regardless of income. Before November, families in Pennsylvania whose incomes were 65 percent or less of the median income could receive free child care. Now every family must pay at least $20 per month. As a result of these changes, according to the Keystone Kids, an organization to which the Junior League of Pittsburgh belongs, parents who formerly paid $800 a year in child-care expenses now are faced with paying $2,000 or more. Two hundred of the 1,900 children receiving subsidized care in Allegheny County were eliminated from the program as a result of the changes. A survey done in January of 135 of these children's parents showed that 45 percent of the parents had not been able to find substitute care. Forty-three percent of the parents who could not find substitute care had annual incomes of under $10,000 a year and almost three-quarters of them were single women.

In Onondaga County, New York, the director of the Onondaga Child Care Council, an organization whose Board includes a representative of the Junior League of Syracuse, reports that the county will have to eliminate all child care provided for low-income working parents by October 1 unless the state legislature passes a supplemental funding bill of 20 million dollars. Without the supplemental funds, child-care centers in Onondaga County will have to charge parents the full cost of care, thus ending services to all children whose parents cannot pay the full fees. If President Reagan's most recent proposals are accepted, Onondaga County still will have to eliminate the programs for low-income working parents, even if the state supplemental appropriations bill is passed. Similar situations exist in several other New York counties. At least one county, Monroe, already has eliminated child care for low-income working parents.

The situation in New York, as in many states, is complicated by the fact that the state and the counties have different fiscal years than the federal government. For instance, the current federal fiscal year began October 1, 1981. Onondaga County's fiscal year began January 1 and the State of New York will begin its new fiscal year April 1. This disparity in the beginning of the fiscal years makes it very difficult to gauge the effects of the most recent budget cuts at this time.

Many of those who supported the first round of budget cutbacks also are requesting a halt to further cuts in social services. For instance, in November 1981, the Junior League of St. Louis joined the National Council of Jewish Women (St. Louis section) and the Missouri Child Care Association in writing to President Reagan to oppose further cuts in the social services. In their view:

> The first round of cuts was difficult but necessary, and our communities are dealing with them in a spirit of co-operation. The second round of cuts, proposed for Congressional action later this month, however, causes us concern.

Since the President first proposed a $1.9 billion ceiling for the Title XX Social Services Block Grant in November, the concerns of the three organizations are valid today. Their letter said the following reductions in children's programs were likely to occur if the Social Services Block Grant was cut to the level requested by President Reagan:

- Family counseling services will be substantially reduced.

- Preventive child abuse and neglect services will be eliminated.

- Child abuse and neglect cases will be maintained for only one year.

- Day care services will be reduced by 18 percent in addition to a 22 percent cut sustained in the first round.

- Three group homes for delinquent children will be closed.

- Residential services for children will be reduced by 18 percent in addition to a five-percent cut sustained in the first round.

The three organizations also wrote Governor Christopher Bond to thank him for "his courageous and thoughtful objections to the second round of social-service-related budget cuts proposed by President Reagan."

The difficulties the poor, especially the working poor, are having in obtaining appropriate child care will be further exacerbated if Congress accepts President Reagan's proposal to eliminate funding for the Work Incentive Program (WIN).

Similar stories, I am sure, could be reported from all parts of the country. We hope by the end of this fiscal year to have more comprehensive reports of the effects of the budget cuts on children's programs. The Association is collaborating with the Children's Defense Fund in developing Child Watch to monitor the effects of the federal budget cuts on children's programs in four areas: AFDC, child health, child welfare and child care. Six Junior Leagues, including the Junior League of Wichita, are conducting Child Watch projects in their communities. Two Junior Leagues--Indianapolis, Indiana and Jacksonville, Florida--will participate in the Public Expenditures for Children project developed by the Foundation for Child Development to analyze the effect of the Administration's budget actions on children's programs in six cities. We hope that these monitoring efforts will develop information that will help Junior Leagues to effectively assess the needs of their community's children, and we look forward to sharing this information with you.

Maternal and Child Health Block Grant

Finally, I would like to touch briefly on the Maternal and Child Health Block Grant established in the Omnibus Budget Reconciliation Act by consolidating seven separate programs: Title V of the Social Security Act (Maternal and Child Health and Crippled Children's Programs); Sudden Infant Death Syndrome (SIDS); Hemophilia Diagnostic and Treatment Centers; Supplemental Security Income (SSI) for disabled children; lead-based paint poisoning prevention programs; genetic disease research; and adolescent pregnancy programs. The Association supported the development of this block grant because we believe that it is essential to maintain a discrete block of money for maternal and child health programs, rather than lumping health programs for all age groups together.

We urge that no further cuts be made in this block grant since the Budget Reconciliation Act reduced the funding for the block grant by 17 percent from the funding levels provided for the programs in the block grant for Fiscal Year 1981. The third continuing resolution reduced the funding for the MCH Block Grant by another four to six percent. We urge that no further reductions be made at this time, especially in light of the spiraling costs of medical care. We also are concerned about the effect the proposed merger of the MCH block grant with the Women, Infants and Children Supplemental Food Program (WIC) would have on the child health programs, particularly when a $282 million dollar cut is proposed for WIC.

In conclusion, I urge you to continue to safeguard the health and lives of our nation's neediest women and children by providing adequate funding for the programs that serve them and preserving P.L. 96-272.

Thank you for this opportunity to appear before you today.

Jan Deering
Public Policy Chairman
The Association of Junior Leagues, Inc.

The CHAIRMAN. Let's see; do you have an order there?

Ms. BLACK. Would you like me to go next? All right.

The CHAIRMAN. Again let me say that we will put your entire statement in the record. You don't need to read it to me; and if you could summarize, it would be very helpful.

STATEMENT OF JOYCE BLACK, PRESIDENT, CHILD WELFARE LEAGUE OF AMERICA, INC., NEW YORK, N.Y.

Ms. BLACK. Thank you. This is a very short summary of my written testimony.

My name is Joyce Black, and I am president of the Child Welfare League of America. CWLA was established at the request of the delegates to the first White House Conference on Children in 1920. It is also the first, and continues to be, the only national not-for-profit voluntary membership organization which sets standards for child welfare services. Our members provide crosscutting services to children, youth, and families. The league has 400 member agencies and, through the office of regional, provincial, and State child care associations, represents 1,600 agencies which are affiliated with 30 State child care associations.

This means that members and affiliated agencies of the league serve several million children nationally. It also means we speak for over 6,000 volunteer board members and several thousand more direct service volunteers.

This, then, is the uniqueness of CWLA. We are not only an advocacy organization but our agencies serve children and their families in every State in the country.

As a concerned citizen who has been a full-time volunteer in the health and human services field for the greater part of my adult life, I was pleased to be invited to speak with you today. I have enormous respect for the professionals and staff in the field, but I believe that is very important for you to hear from those of us who, at the local, State, and national level, volunteer our time to direct service activities with children, youth, and families as well as make policy decisions regarding programs and fundraising for agencies who care for our Nation's 64 million children; in particular, those children who cannot speak for themselves and who suffer the most from the administration's severe cutback in social welfare programs.

It is important to note that a mere 18 percent of the Federal Government's transfer payments are for people with very limited or no resources. Although these means tested programs represent only 18 percent of the transfer payments, 60 percent of the fiscal year 1983 budget cuts are targeted at these programs. These are the programs in which children represent well over half of the recipients. Children are barely surviving the fiscal year 1982 cuts, and in my opinion the proposed 1983 cuts will have disastrous results, such as possible warehousing of children, and will also negatively affect the Nation's economy.

I would like to speak briefly to three different proposed program cutbacks.

Cuts in AFDC: The study recently completed by Tom Joe, Director of the University of Chicago's Center for the Study of Social

Policy, concludes that the proposed budget cuts in entitlements for AFDC recipients will fail to achieve the anticipated savings.

Why? Because of the work-disincentive impact of the new proposal, it would not achieve the savings predicted by the administration. Each time a mother leaves a job or fails to accept a job because of the built-in disincentives, there is a substantial increase in the Federal Government cost. Federal AFDC and food stamp benefits are far higher for a family that does not work and has no other income than for a family that has some earnings and therefore qualifies for smaller welfare and food stamp benefits.

When the work disincentives in the AFDC/food stamp/medicaid system become too great and fewer persons work, much of the savings Congress thought it was achieving disappear and Federal costs actually increase rather than decrease.

Second, cuts in Public Law 96-272, the Adoption Assistance and Child Welfare Act. The administration's proposal in this area would reduce the funding level for this program by 25 percent from the 1982 level, which will be 47 percent below what Congress recommended be available for implementation in 1983 when the bill was drafted.

The administration also proposes block-granting 96-272. We find this contrary to the spirit and intent of the legislation—the legislation that so many of you worked on to make a reality. Foster care meets the basic survival needs of children and must be provided in order for a child to exist.

In addition, the league wants, as the legislation states, to move children back to their natural families or into permanent adoptive homes. This service for permanency costs money; it does not happen by wishing or infusing good willed, nontrained volunteers into the system. Up-front money will, in the long run, save millions of dollars in possible residential treatment care or detention facilities.

For instance, the Maine Department of Human Resources reports a 10-percent decline in the number of children in care last year because of increased family remunification and adoption services. And the 1982 Foster Care Review Report from the Arizona Supreme Court states that it costs Arizona $10,000, including the administration cost, to maintain a child in foster care for 1 year, but only $1,600 a year for a child in subsidized adoption.

Last, Title XX, Social Services Block Grant: This was cut in 1982 by 23 percent, and it is proposed to be cut by another 20 percent in 1983.

Since August of 1981 this would mean a 38-percent reduction, or $1.225 billion, which does not include loss of State matching funds nor the administration's proposal for folding in WIN.

Approximately 62 percent of Title XX Social Services Block Grants are expended on children and families. For instance, there has been a 17-percent increase in abuse and neglect nationally in the past year. We all read the tragic stories of mothers abusing their babies to the point of death. We know from former studies that much of this can be prevented with foster care services. We also know that the closing of day care centers—and if this budget is allowed to stand there will be many, many more—will not only adversely affect children but the economy. Caretakers will be without jobs, and many single parents who head households will stay home and not work because private costs of care such as babysitters are unaffordable. This will, again, swell the public assistance rolls and will be far more costly to the taxpayers, both individuals and corporations.

It is not a pretty picture, but you can do something about it.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statements follow:]

TESTIMONY OF

THE CHILD WELFARE LEAGUE OF AMERICA, INC.

My name is Joyce Black, and I am the President of the Board of Directors of the Child Welfare League of America (CWLA). I have served on the Board of CWLA since 1975. I have devoted my career to volunteer leadership activities, and am currently serving on boards of local, state and national organizations. I am the President of the Day Care Council of New York, Inc.; President, Big Brothers of New York, Inc.; Vice President, Volunteer - The National Center for Citizen Involvement; Vice President, Big Brothers/Big Sisters of America (first woman trustee); member, New York State Banking Board (first woman member); Co-Chairperson, Mayor's Voluntary Action Council; member, New York State Temporary Commission on Child Welfare; Trustee (first woman), New York University Medical Center; Past Chairperson, Resources Review Board; Board Member, Council on Accreditation of Services for Families and Children; Vice President, National Conference on Social Welfare; Board Member, New York Council for the Humanities; Vice President, Cancer Care, National Cancer Foundation, New York State Board of Social Welfare.

The Child Welfare League of America was established in 1920 and is the only national voluntary membership and standard setting organization for child welfare agencies in the United States. Our agencies provide adoption services, day care, day treatment, foster care, residential treatment, maternity home care, protective services, homemaker services, emergency shelter care, services for children in their own homes and services for children and families under stress. The League is a privately supported organization comprised of 400 child welfare agencies in North America whose efforts are directed to the improvement of care and services for children. The agencies affiliated with the League include all religious groups as well as non-sectarian public and private nonprofit agencies. Through the Office of Regional, Provincial and State Child Care Associations, the Child Welfare League also represents 1,600 child care agencies affiliated with 30 State Child Care Associations.

I would like to thank the Finance Committee for the opportunity to appear before you today, on behalf of the Child Welfare League of America, to express our concerns regarding the Administration's Fiscal Year 1983 budget proposals.

We as a Nation have always embraced oppressed people. Indeed, America is known as the land of opportunity. Yet it is a sad, clear fact that the brunt of the Administration's 1983 budget cuts will be borne by children, just as the FY 1982 budget cuts were. What kind of opportunity are we providing our children when we deny them their basic survival needs and the services necessary for them to live a fruitful life?

A mere 18 percent of the federal government's transfer payments are for people with very limited, or no resources. Although these means-tested programs represent only 18 percent of the transfer payments, 60 percent of the FY 1983 budget cuts are targeted at these programs. These are the programs in which children represent well over half of the recipients. We protest the inherent unfairness of these budget cuts. The Administration's policies of redistribution of income from the poor to other segments of our society must not be allowed to continue.

We are cognizant that basic economic stabilization is a necessity for a strong America. However, these additional cuts in human service programs will not lead to economic stability, but in the long run will cause increased deficits and human suffering.

The Administration's budget proposals for FY 1983 recommend large reductions in programs aimed at assisting the poor and disadvantaged. The following chart demonstrates certain program reductions enacted, and proposed, under this Administration.

SUMMARY OF THE PRESIDENT'S BUDGET PROPOSALS

	FY 1981	FY 1982	FY 1983
Child Welfare Block Grant	$522 million	$460 million*	$380 million
Title XX Social Services Block Grant	$2.9 billion	$2.4 billion	$1.9 billion
Aid to Families with Dependent Children	$7.0 billion	$7.1 billion	$5.7 billion
Medicaid	$16.8 billion	$17.8 billion	$17 billion
Food Stamps	$10.5 billion	$10.6 billion	$9.5 billion
Child Nutrition	$3.5 billion	$2.8 billion	$2.8 billion
Compensatory Education (Title I)	$3.1 billion	$2.9 billion	$1.9 billion
Education for Handicapped Children	$1.4 billion	$783 million	Block Grant
Juvenile Justice	$100 million	$70 million	0
Comprehensive Employment and Training Act (CETA)	$7.6 billion	$3 billion	$387 million
Work Incentive (WIN)	$365 million	$246 million	0
Head Start	$820 million	$912 million	$912 million
Runaway and Homeless Youth	$10.9 million	$10.5 million	$6.6 million
Child Abuse	$6.8 million	$6.7 million	$4.6 million

*plus $46.9 million CBO estimates will be required in a supplemental appropriation to meet foster care expenditures.

Even a primitive analysis of last year's activity and this year's proposals by the Administration reveals that the poor are getting poorer, and that the working poor can find safety only in dropping back to AFDC where they will be guaranteed Medicaid protection for their children. America's poor are increasing in numbers. Poverty may become a more permanent status as avenues for upward mobility are eliminated, and children, the next generation, are be consigned to poverty as they were in the 1950's. Clearly, children and children's programs are suffering.

For instance, policy analysts predict that under the proposed Fiscal Year 1983 cuts:

- 750,000 pregnant women will become ineligible for federally-funded, prenatal nutrition programs.

- 100,000 families will no longer receive day care services -- services which allow parents to work.

- AFDC will again be cut, eligibility will be tightened, and struggling children and their families will be faced with the most draconian of decisions -- whether to pay for food or heat, whether to pay for housing or transportation to a job.
- one million school children will not receive meals in the Summer Feeding Program, now slated for elimination.
- Millions of children will have less medical attention.
- Millions of children will have less to eat because of eligibility changes and reductions in the number of meals in day care centers. Have we so quickly forgotten the distended bellies of some of our children only a little over a decade ago?

State officials are predicting that those working in marginal jobs will be forced to stop working and exist on AFDC alone in order to retain medical coverage for their children. This fact was corroborated by Tom Joe, head of the University of Chicago's Center for the Study of Social Policy here in Washington D.C. Joe, a welfare expert, who worked in the Nixon administration, has concluded, "if the Reagan proposals go through, the cuts for the working poor would provide a clear disincentive to work. In 24 states a welfare mother with 2 children would end up getting more disposable income if she depended solely on welfare than if she went out and took (or kept) an average job...In New York, for example, the non-working family would get $508 as against $468" (WASHINGTON POST, February 25, 1982).

The effect of the Administration's new proposals in the food stamp and Aid to Families with Dependent Children (AFDC) programs -- when added to the effect of last year's reductions in these programs -- will be to push low income families deeper into poverty and virtually eliminate any incentives for welfare mothers to work. Joe's study further shows the effects on:

Work Incentives

- Before last year's changes, those AFDC mothers who went out and worked (and earned average wages for working AFDC mothers) were able to raise their disposable incomes to the poverty level in 29 states. After last year's cuts, average AFDC working mothers were pushed below the poverty line in every state. Under the new proposals, they would be dropped to 85 percent of the poverty line or below in every state.
- Incomes for working AFDC families would be reduced so much that parents who work would generally be little better off -- or worse off -- than AFDC mothers who do not work. In 24 of the 48 states included in the study, the AFDC working mother earning average wages would end up with less disposable income than the AFDC mother who does not work. In California, the working mother would have $82 a month (or nearly $1,000 a year) less in disposable income than the mother who does not work at all. These 24 states include 65 percent of all AFDC working parents. This is shown in Appendix I.

- The 24 states where working parents would be worse off are Arizona; California; Colorado; Connecticut; Georgia; Illinois; Iowa; Kansas; Louisiana; Massachusetts; Michigan; Minnesota; Montana; Nebraska; New Hampshire; New Jersey; New York; Ohio; Rhode Island; Utah; Vermont; Washington; Wisconsin; and Wyoming.

- In half of the remaining states, the average working AFDC mother would end up with from $4 to $29 more per month (or no more than about $1 a day) from working. These states are Florida; Idaho; Indiana; New Mexico; Oklahoma; Oregon; Pennsylvania; South Dakota; Virginia; West Virginia; and the District of Columbia.

- The new proposals would also discourage those who are working from working harder and increasing their earnings. For most AFDC working mothers, each additional dollar they earn after their first four months on the job will result in a net income gain of only one cent. Ninety-nine cents would be "taxed away" through reductions in AFDC and food stamp benefits and increases in Social Security and payroll taxes.

- These extraordinarily high "combined marginal tax rates" destroy work incentives. They are contrary to the philosophy behind the major tax reductions for upper income individuals in last year's tax bill. Wealthy individuals in the highest tax brackets now retain at least 50 cents of each additional dollar they earn, a feature of the tax code designed to maintain incentives and spur productivity.

- These features of the new Administration's proposals run counter to statements made in prior years by David Stockman. In a 1978 article in the Journal of the Institute of Socioeconomic Studies, Stockman warned that welfare recipients needed to be able to keep more, not less, of each additional dollar they earned or else incentives to work would be undermined.

Medicaid

- The work disincentive features are further aggravated by the fact that in 20 states, those working families eliminated from the AFDC program also lose Medicaid coverage for themselves and their children. In these 20 states, Medicaid is restricted to those on AFDC or SSI. When working families stand to lose Medicaid coverage for their children because they work, and when their disposable incomes are not much higher than those on welfare who do not work, pressures to leave or decline jobs and go back on welfare intensify.

- The new budget proposals would exacerbate this situation by reducing the federal matching rate for the Medicaid costs of working poor families not on AFDC in those states that still cover these families. As a result of last year's substantial reductions in federal Medicaid funding, some of the remaining 30 states are already restricting or even planning to drop medical coverage for the working poor. If this new Medicaid reduction proposal by the Administration is added on top of last year's cuts, larger numbers of states are likely to begin reducing or terminating medical coverage for the working poor.

Child Care Support

- In addition to AFDC, food stamp and Medicaid cuts aimed at the working poor, work disincentive impacts are also beginning to result from sharp cuts in federal funding for day care services provided to low income working families. The combined impact of these reductions has been to force some day care centers to close, to lead others to reduce the number of children they can serve, and to lead many to raise day care fees. When any of these events occur, some low income working families are forced to pay more for child care services. The result is that the costs of working go up, and the gains from working diminish.

Joe concludes by stating that the proposed cuts in entitlements will fail to achieve anticipated savings.

- Because of the work disincentive impacts of the new proposals, they would not achieve the savings predicted by the Administration. Each time a mother leaves a job or fails to accept a job because of the built-in disincentives, there is a substantial increase in the federal government's costs. Federal AFDC and food stamp cenefits are far higher for a family that does not work and has no other income than for a family that has some earnings, and therefore qualifies for smaller welfare and food stamp benefits. When the work disincentives in the AFDC/food stamp/Medicaid system become too great and fewer persons work, much of the savings the Congress thought it was achieving disappear, and federal costs actually increase rather than decrease.

- Federal costs for AFDC and food stamp benefits for an average AFDC working family averaged $189.80 a month, prior to last year's changes. The federal cost for a family that does not work would be $279 a month next year. Each time an AFDC mother chooses not to work because of the new disincentive features, federal costs to support her family are 47 pecent higher than if she had taken a job.

The charts in Appendix I from Tom Joe's study show: 1) a comparison of the Effect of Employment on the Monthly Disposable Income of AFDC Families; and 2) the Rise in Federal Costs if Work Effort is Reduced.

P.L. 96-272, THE ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980 vs. ADMINISTRATION CHILD WELFARE BLOCK GRANT PROPOSAL

Description of Current Law

After five years of intensive work, the Adoption Assistance and Child Welfare Act was signed into law on June 17, 1980. In this family support bill Congress established the principle of permanency for all vulnerable children in America, children who in some cases have been in out-of-home placements for years, or bouncing from foster care placement to placement. This Act mandates major reforms in child welfare services through a painstakingly crafted, systematic restructuring of the child welfare system. Federal financial incentives are provided in order for States to:

- -- conduct an inventory of all children in foster care over six months;
- -- implement a statewide management information system on children in foster care;
- -- implement a case review system;
- -- implement a family reunification services program; and
- -- implement a preventive services program.

Realizing that without alternatives to foster care, the system could not be reformed, Congress placed new emphasis on increasing federal Title IV-B child welfare services funds and created a federal Adoption Assistance Program to provide those necessary alternatives: incentives for adoption and family strengthening services.

Only when specific increases in federal Title IV-B child welfare funds were appropriated to provide these alternatives, and shifted to an advanced funding basis, would a cap on federal expenditures for AFDC-foster care be imposed. The law specifies that by October 1, 1982 Title IV-A, AFDC-foster care, be converted into a new Title IV-E AFDC-foster care program, and the new Title IV-E Adoption Assistance program for AFDC or SSI special needs children be mandatory. Congress felt so strongly about this bill that it became dramatically bi-partisan -- enacted by a 402 to 2 vote in the House, and a unanimous vote in the Senate.

The Administration's budget document gives this rationale for the elimination of P.L. 96-272 through the budget cutting, block-grant process: "Under the current system, States do not have the flexibility to direct their efforts to permanently place children rather than continue foster care arrangements." That statement is totally inaccurate. P.L. 96-272 specifically mandates prevention of unnecessary separation of the children from the parent(s); improved quality of care and services to children and their families; and permanency through reunification with parents or through adoption or other permanency planning.

During the first session of the 97th Congress the Administration proposed folding child welfare programs into the Title XX Social Services Block Grant and dramatically reducing the funding necessary to implement the required improvements in the child welfare system. Congress did not agree. Instead, Congress reaffirmed its commitment to maintaining the flexibility in P.L. 96-272 and providing necessary alternatives for children in need of services by protecting the law and its funding levels in the Omnibus Budget Reconciliation Act.

Although the law has not had the opportunity to be fully implemented yet, the Administration is once again proposing its elimination. This time a new Title IV-E Child Welfare Block Grant is proposed by the Administration which would consolidate Title IV-B Child Welfare Services, Child Welfare Training, Title IV-A/E Foster Care, and the Title IV-E Adoption Assistance program for special needs children. This proposal would eliminate the individual entitlement to care for special needs adoptive and foster children, and it would repeal the Title IV-B child welfare services program for vulnerable children that Congress enacted along with the Social Security Act back in 1935.

The authorization level for the block grant would only be $380 million for FY 1983 and thereafter. Since the program would only be authorized at that low level, and since lesser sums could be requested by the Administration and appropriated by Congress, States would never have a firm federal commitment to meet the most basic needs of our vulnerable children, much less the financial support to improve the child welfare system as presently embodied in P.L. 96-272.

P.L. 96-272 Incentives Lost by Inclusion in Block Grant

Open-end Adoption Assistance Program for AFDC and SSI eligible special needs children: Inclusion in a block grant eliminates the entitlement, and the incentive to move children out of foster care and into adoptive homes, by capping the program and reducing the funding for this alternative to foster care. Special needs children require additional specific adoption placement services that States will be hard pressed to provide under reduced funding levels. There will no longer be an incentive to provide these extra adoption services to children over any other service since funding would be limited and from a single source.

According to the National Study of Social Services to Children and Their Families (July 1978):

- There were at least 100,000 children legally free for adoption in 1977, yet only half of these children were receiving adoption services.
- If proper and appropriate services were provided, it is estimated that at least another 100,000 children would be free for adoption.
- Title XX, the current social service block grant program, has provided less than one percent of the available funds for adoption services in any fiscal year since the program's inception (1975).

Increased funding to implement the new child welfare requirements under the Title IV-B child welfare services program: In 1979 the Title IV-B child welfare services program expenditures were approximately $800 million, 93 percent of which were State and local funds. Yet the States were still incapable of implementing the major reforms embodied in P.L. 96-272. The Federal share of the IV-B program was only $56.5 million until passage of P.L. 96-272, which tied specified increases in Federal funding under IV-B to the new program requirements. Federal funds appropriated above $56.5 milion may not be expended for foster care maintenance, adoption assistance or employment-related day care. Title IV-B appropriations, advanced funded, of $163.5 million for FY 1981, $220 million for FY 1982, and $266 million for both FY 1983 and FY 1984, trigger a ceiling on the AFDC foster care program. In FY '81 $163.5 million was appropriated for child welfare services. In FY '82, under the Continuing Resolution, $163.5 million was appropriated with H.H.S. having the discretion to cut up to 6 percent from the program. HHS reduced child welfare services funding to $156 million for FY '82. However, the Administration only requested that $107.9 million be appropriated for FY '82 -- an amount which would not trigger the reforms in the law.

Title IV-B incentive funds above $141 million: Only those States that have implemented an inventory of children in foster care; a statewide management information system; a case review system; a family reunification services program; and, after appropriations of $266 million for two consecutive years, a preventive services program, are eligible to draw down Federal funds in excess of their share of $141 million. Additionally, when States have received their share of the full authorization, $266 million, for two consecutive years they must have implemented all of the reforms or else the State's share of Title IV-B funds will be reduced to its share of $56.5 million. There would be no incentive funds to encourage States to implement reforms in the block grant approach.

Increased flexibility through transfer of funds from Title IV-E Foster Care program to Title IV-B Child Welfare Services program: With the availability of alternatives to foster care it is anticipated that foster care expenditures will decline. Therefore, for any fiscal year in which funds appropriated under Title IV-B Child Welfare Services are insufficient to trigger a nationwide ceiling on foster care funds, States have the option of operating their foster care program under a limitation (formula specified in P.L. 96-272). As an incentive to reduce foster care with the provision of family strengthening services, States may transfer funds from their allotment not needed for foster care under Title IV-E over to the Title IV-B child welfare services program at the higher matching rate of 75 percent Federal funds. The block grant proposal cuts federal funding by 47 percent in FY '83 and 50 percent by FY '84 as compared to full implementation of the provisions in P.L. 96-272 (see Appendix II for a comparison of funding levels for child welfare programs). With only one limited source of funding to meet the needs of children, States would not have an incentive to provide additional necessary services to move children out of foster care into families. In fact, States would be hard pressed to move children through the foster care system. The Congressional Budget Office (CBO) estimates that $346 million will be needed to fund just the AFDC foster care program in FY '82. Applying the Administration's inflation rate of 7.5 percent to the AFDC foster care program provides a $372 million cost for FY '83, assuming absolutely no increase in the need for out-of-home care for poor children. Under the Administration's proposed block grant funding level, that would leave $8 million to provide the services necessary to move children through the system. It is inconceivable that family reunification and preplacement preventive services, adoption services and assistance, and training for child welfare personnel could be provided for under such dramatic funding reductions.

State and local matching requirement: A 25 percent State/local matching of Federal funds is required in order for States to draw down the 75 percent Federal dollars for the Title IV-B child welfare services program. Inclusion in the block grant eliminates the State/local matching requirement, thereby eroding program dollars further.

Time and resources to implement reforms: Since States are at different stages of development toward these child welfare reforms, under current law mandates are not in place until a State draws down its share of Federal funds in excess of $141 million. The incentive is in place for States to move quickly in order to be eligible for additional resources, but those States that are in the process of developing reforms would not be penalized until sufficient dollars and time have been allowed to have the required services in place. The block grant proposal dramatically cuts the resources to implement the reforms, requires that preventive services be in place by October 1, 1983, and yet allows States which assure the Secretary of HHS that they have not implemented the reforms to receive 80 percent of their allotment plus the portion of the remainder of their allotment which they specify in their report will be spent on those activities.

Conclusion

The Administration is removing the incentives, the fiscal resources, and the flexibility embodied in P.L. 96-272 that Congress so carefully crafted, and still supports, which would enable children to grow up in permanent loving families. The proposed child welfare block grant will perpetuate the pattern of children going into "temporary" foster care and leaving at the age of 18 -- alone, without a family. Foster care is a sound program that has protected many children from harm, but it has been overutilized due to lack of alternative services for vulnerable children and their families. We must not turn back the clock by making the alternatives to foster care unavailable. States must be able to provide a full complement of services, as contained in P.L. 96-272, which a block grant reduced by 47 percent will not allow them to do.

So a law could be lost, a cost-effective and humane law. Congress is being asked to take a lot of money, and a lot of hope, away from kids and to renege on the nation's promise that kids in need of care are entitled to receive care. Add to this the cuts in the basic funding stream for social services for children and their families, the Title XX Social Services Block Grant, the cuts in AFDC and you have an abdication of federal responsibility for children.

The reforms initiated by P.L. 96-272 grew out of substantial work by members of Congress, child welfare service providers, child advocates, and researchers. The results are quite impressive.

Kansas

Marjorie B. Morgan, Commissioner of Social Services in the Kansas Department of Social and Rehabilitative Services (SRS) reports:

> "Kansas has an enviable record in showing its concern for people through effective programs to prevent child abuse and neglect and to protect our children. Any further reductions in the IV-B and IV-E funds will severely curtail our preventive and protective services to protect our children and to maintain intact families.
>
> "As you are aware the expenditure of monies directed toward programs which prevent children from entering foster care and those which enable children to move from the foster care system into permanent adoptive homes are cost

effective. In Kansas the Adoption Support program is one of the most cost effective programs we have due to its ability to reduce the number of children caught permanently in the foster care system. The average cost of adoption support for children receiving medical services and/or case maintenance payments is $154.00 per month, per child, while the average cost of foster care is approximately $451.00 per month, per child, excluding medical costs."

In other words, $297 per child, per month, is saved by providing adoption support to needy children. The Administration's 25 percent reduction from FY 1982 funding levels for child welfare programs would mean that 21 additional children could remain in foster care, since the resources to provide additional family building services would be severely curtailed. The anticipated cost of retaining 21 additional children in the foster care system in Fiscal Year 1983 would result in an unnecessary drain of $74,844 on the Kansas foster care budget. However, there is no way to calculate the human cost to a child denied a permanent loving family.

A Special Report on Foster Care prepared by the Kansas Department of Social and Rehabilitation Services (January, 1982) shows the following data from the SRS Child Tracking System:

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REASON FOR CLOSING OF CUSTODY CASES

It should be noted that cases are being closed at an increasing rate as permanency planning concepts for children have been implemented. In the first six months of FY 1982, 2,095 children were released from agency custody as compared to 2,952 closing in all of FY 1980 and 2,396 cases in all of FY 1979. Data available in the child tracking system show that children are remaining in the system for a shorter period of time.

	Custody Returned to Parents	Child Reached Age of Majority	Custody Transferred to Other	Adoption Finalized	Other*	Total
July 1981	225	84	32	30	103	474
Aug. 1981	189	78	36	31	105	439
Sept. 1981	167	45	25	18	63	318
Oct. 1981	234	63	29	35	67	428
Nov. 1981	79	24	9	11	18	141
Dec. 1981	166	41	27	25	36	295
					GRAND TOTAL:	2095

* The "Other" code includes "Entered in Error." The decreasing use of this code reflects the agency's efforts at "cleaning-up" this new tracking system.

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Arizona

The 1982 Arizona Supreme Court Report and Recommendations regarding Foster Care Review Boards shows the following cost effectiveness data of permanency provisions through adoption subsidy:

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Direct Comparative Cost: Foster Care vs. Subsidy
(As of July 1, 1980 -- Source: DES)

Average Cost of Child in Foster Care (Direct cost only)*	Average Cost of Child in Subsidy
$7,014 a year	$1,600 a year

* When all costs, including administration and personnel are involved, the average cost exceeds $10,000 a year.

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Virginia

Loudon County Department of Social Services reports:

> "As a result of this agency's knowledge of children's need for permanency, we hired a permanent planning worker in February of 1977. Her caseload was selected on the basis of which foster children had the greatest need for permanency. This worker has been involved with twenty-five families with a total of fifty-five children. Eighteen children have been returned to biological families. Ten other older children remained in continued foster care. Eleven children have been released for adoption. Four of these children were adopted by their foster parents; seven children, including a sibling group of three, were adopted, and we are actively working on placing one child who is emotionally disturbed Four children went into permanent foster care. (These are older children who wanted to remain with their foster parents and not be adopted.) We are still working on plans for five children. As of February 1982 these efforts have resulted in a financial savings of $128,749 in foster care payments alone. The salary for the permanent planning worker during the same period was $32,000. The Loudon County Department of Social Services currently has forty-five children in foster care placement. We have had a 25 percent reduction in the number of children coming into foster care during a period of time when the population in the county has increased."

The Commonwealth of Virginia foster care program provides substitute homes for 8,183 children. The majority (53 percent) of the children in care are 13 years of age or older.

The 2,145 children who entered foster care last year (Fiscal Year 1980-1981) came into the custody of the local boards of welfare for the following reasons:

Abuse or neglect	40 percent of children
Temporary relinquishment of custody	24 percent of children
Children in Need of Services (Non-Delinquent Violations of Law)	17 percent of children
Parents Requested to be Relieved of Custody	13 percent of children
Delinquency	3 percent of children
Reason Indeterminable from Automated Data System	3 percent of children

Of those children who entered care last year, 41 percent had fathers and 14 percent had mothers who were absent from the home or who deserted. Twenty-seven percent of the children had mothers who needed services primarily to help them manage and care for their children.

As of June 1981, 50.5 percent of the children were white and 49.5 percent were non-white; 53 percent were male and 47 percent were female. Forty-one percent of the children in care had one or more physical, mental, or emotional handicap.

While the average length of time in care is 4.3 years, the number of children who remain in care for over 2 years is decreasing. Of the 3,353 children who left care last year, 47 percent of them were returned to their parents and 16 percent were adopted.

Oregon

A report from the Children's Services Division of the Oregon Department of Human Services on their 1980 Permanency Planning Services Program for children in need of special planning services reveals that:

- special planning services were provided to an average of 580 children per month;
- during one month's time, out of 661 children served, 234 or 35 percent were returned home;
- the Oregon Legislature recognized that permanency planning was saving money from out of home placement costs and decided to appropriate funds for preventive and restorative services, including, but not limited to: homemaker, housekeeper, incest treatment, parent training, supportive remedial day care, and intensive family services to address the increasing level of problem severity;
- from March 1980 until December 1980, 370 families were provided intensive family services -- out of 193 children approved for substitute care placement only 10 children required placement due to the provision of intensive family services;
- during the same period (March 1980-December 1980) a control group of 20 families was monitored -- all required placement;
- results show that with three months of intensive family services, 95 percent of the children will remain at home, or be returned home, who would have required out of home placement without the intensive services;

- cost effectiveness of permanency planning services:
  - -- average monthly cost of substitute care per child is $754;
  - -- average monthly cost of services per child is $333;
  - -- in 1958 average length of stay for a child in substitute care was 58 months;
  - -- in 1979 average length of stay for a child in substitute care was reduced to 26 1/2 months;
  - -- from March 1980 to January 1981, the Department estimated savings of $945,000, using the average length of stay for children in out of home care, for children not placed in substitute care;
  - -- Oregon estimates an 800 percent return on their investment in services to children and their families based on costs of the average length of stay in out of home care.

California

COST EFFECTIVENESS OF ADOPTIVE PLACEMENT VS. BOARD AND CARE COST
OF LOS ANGELES COUNTY CHILDREN
Fiscal Year 1979-80

	First 12 Months	To Age 18
All Placements (557) (a)		
Board and Care Costs	$1,696,452	$18,430,651
Aid for Adoption Costs	- 226,093	- 904,373 (b)
SAVINGS:	$1,470,359	$17,526,278
Placements Without AAC (398) 69.8% of Total		
Board and Care Costs	$1,140,064	$13,517,040
Aid for Adoption Costs	-0-	-0-
SAVINGS:	$1,140,064	$13,517,040
Placements With AAC (168) 30.2% of Total)		
Board and Care Costs	$ 556,388	$ 4,913,611
Aid for Adoption Costs	- 226,093	- 904,373
SAVINGS:	$ 330,295	$ 4,009,238

(a) Does not include 31 out-of-county children placed with Los Angeles County families for whom savings will accrue in the county from which they were placed.

(b) Based on 4-year average period of subsidy.

Title XX Social Services Block Grant

As part of President Nixon's "new federalism", federal programs for social services were consolidated under Title XX of the Social Security Act as a capped block grant program administered by the states in 1975. With a federal funding ceiling of $2.5 billion and a 25 percent matching requirement, all social service programs formerly under AFDC and aid to the aging, blind and disabled (Titles I, IV-A, X, XIV and XVI of the Social Security Act) became a single block grant to states. Social services were separated from income maintenance and assigned a primary goal of reducing dependency and promoting self sufficiency. States were given responsibility for determining their own social services needs and for allocating resources to provide soical services, with a condition that there be broad public participation in this decision-making process.

This program is the principal Federal funding source for the full range of social services as determined by the State. Services are to be directed toward five goals: 1) self-support; 2) self-sufficiency; 3) prevention and remedy of neglect, abuse or exploitation of children or adults and preservation of families; 4) prevention of inappropriate institutional care through community based programs; and 5) provision of institutional care where appropriate.

Approximately 62 percent of the program funds have been expended for services to children and their families. A large percentage of day care for low-income families, which enables parents to work, is provided under Title XX. Increased demand on services offered under the Title XX program is expected once the impact of other reductions in programs like AFDC, Medicaid, food stamps, housing, CETA, and low-income energy assistance is felt. Additionally, substantial funding cuts have strained the States' ability to implement the bipartisan supported reforms contained in the Adoption Assistance and Child Welfare Act of 1980. Any further reduction in the Social Services Block Grant could effectively halt States' efforts to find permanent homes for children.

Under the Omnibus Budget Reconciliation Act, the Title XX Block Grant was amended to incorporate social services, day care, state and local training, and social services for the territories into a new block grant program to the States. States were given increased flexibility within this new block grant. There is no longer a state match requirement, State planning and public participation requirement, earmarking of specific funds for day care, nor targeting of funds toward low-income recipients. Funding was cut by 23 percent (almost $700 million) for FY 1982. The current funding level for FY 1982 is $2.4 billion as compared to the $3.099 billion it would have been before Reconciliation.The Office of Human Development Services estimated that, with inflation, $4.7 billion in federal funds would have been required to maintain FY 1980 social services at the level orginally funded with $2.5 billion when the Title XX program began. States have been coping with seven years of tight funding by reducing services, restricting eligibility, eliminating services to less powerful political constituencies, and redeploying funds where possible.

The Administration has requested an additional 20 percent cut ($476 million) from the level enacted during Reconciliation for the FY 1983 Title XX program. New language is proposed that would delete the incremental increases in funding for the program and would also allow Title IV-C Work Incentive Programs (WIN) and WIN demonstration projects to be provided for under Title XX although no additional revenues would be provided. WIN was funded at $365 million in FY 1981 and $256 million in FY 1982, zero funding is requested for FY 1983. The Administration budget request of $1.974 billion would be the total amount of federal funds available for Title XX including the WIN programs and demonstraton projects should States choose to continue those programs. The FY 1983 budget request represents a loss of $1.225 billion (a 38% cut) in federal dollars for Title XX just since August 1981 (see Appendix III).

In order for States to plan their programs rationally and expend resources in a responsible manner, stabilization of federal funding is needed. States are still reeling from the impact of last year's budget cuts and will not be able to meet the needs of vulnerable children and their families or other individuals in need of services. Various parts of the state social service systems will begin to collapse.

Given that this is a period of high inflation and increasing unemployment compounded by a severe winter, families are experiencing greater and greater stress. Unfortunately, too often this stress translates into child abuse and neglect, family disorganization and juvenile delinquency. This increases the need for social services to the family and its individual members.

The recently completed National Study of the Incidence and Severity of Child Abuse and Neglect projects an incidence rate of approximately one million children who are seriously abused or neglected in this country each year. The numbers of these children who are reported to public child protection agencies for investigation and child protective action continues to increase, with the rate of substantiated cases increasing over 17 percent in the last two reporting years.

The vast majority of protective services are provided for through the Title XX program. It is impossible to understand how the Administration expects States to meet a 17 percent increase in the need for protective services under a program suffering from a 38 percent reduction (enacted and proposed) since August 1981.

Let's look at the cuts in Title XX:

- Kansas reports that it has reduced day care by 50 percent, which will cause additional problems for marginally employed families.

  "In the first six months of Kansas' fiscal year 1982, 1,894 families were confirmed as abusing/neglecting their children; an additional 1,169 families were found to be at risk of future abuse or neglect of their children unless preventive services were available. Under increasing stress, not only will there be more families who abuse and neglect their children, but the children and youth will be subjected to more severe abuse and greater neglect." (See Appendix IV for incidence of child abuse/neglect in Kansas.)

- Kansas sustained a cut of $6.9 million in FY 1982, and an additional 20 percent cut of $4.9 million is proposed for FY 1983.

- Oregon sustained a $4.4 million cut in FY 1982, and an additional 20 percent cut of $5.4 million is proposed for FY 1983.
- Delaware sustained a $1.6 million cut in FY 1982, and an additional 20 percent cut of $1.2 million is proposed for FY 1983.
- Missouri sustained a $14 million cut in FY 1982, and an additional 20 percent cut of $10.3 million is proposed for FY 1983.
- Rhode Island sustained a $2.9 cut in FY 1982, and an additional 20 percent cut of $2 million is proposed for FY 1983.
- Pennsylvania sustained a $35.2 million cut in FY 1982, and an additional 20 percent cut of $24.7 million is proposed for FY 1983.
- Wyoming sustained a $971,000 cut in FY 1982, and an additional 20 percent cut of $983,000 is proposed for FY 1983.
- Minnesota sustained an $11 million cut in FY 1982, and an additional 20 percent cut of $8.5 million is proposed for FY 1983. According to Public Welfare Commissioner Arthur E. Noot, "Minnesota has not had such a shortfall in revenue since the early '30s." There is less coming in from corporate taxes and sales taxes. If the economy does not pick up, the shortfall will continue. Noot anticipates there will be a $1 billion shortfall out of an $8 billion budget. On top of this are the reductions in Federal funds to Minnesota. Noot estimates that, given the new regulations, Minnesota will lose $21.1 million in Federal AFDC funds and $8.3 million in Medicaid funds.
- Colorado sustained a $5 million cut in FY 1982, and an additional 20 percent cut of $6 million is proposed for FY 1983.
- Idaho sustained a $2 million cut in FY 1982, and an additional 20 percent cut of $2 million is proposed for FY 1983.
- Iowa sustained a $8.6 million cut in FY 1982, and an additional 20 percent cut of $6 million is proposed for FY 1983.
- Louisiana sustained a $10 million cut in FY 1982, and an additional 20 percent cut of $8.7 million is proposed for FY 1983.
- Virginia sustained a $13.7 million cut in FY 1982, and an additional 20 percent cut of $11.6 million is proposed for FY 1983.
- Texas sustained a $27.8 million cut in FY 1982, and an additional 20 percent cut of $29.7 million is proposed for FY 1983.
- Hawaii sustained a $2 million cut in FY 1982, and an additional 20 percent cut of $2 million is proposed for FY 1983.
- New York sustained a $58.9 million cut in FY 1982, and an additional 20 percent cut of $36.7 million is proposed for FY 1983.

- Montana sustained a $2.7 million cut in FY 1982, and an additional 20 percent cut of $1.6 million is proposed for FY 1983.

- Oklahoma sustained a $7.2 million cut in FY 1982, and an additional 20 percent cut of $6.3 million is proposed for FY 1983.

- New Jersey sustained a $21.7 million cut in FY 1982, and an additional 20 percent cut of $15.4 million is proposed for FY 1983.

- Maine sustained a $3.3 million cut in FY 1982, and an additional 20 percent cut of $2.3 million is proposed for FY 1983.

The results are being felt. For State human service agencies, the issue is money, not New Federalism. So concludes the report, "A Study of the Implementation of the Social Service Block Grant in State Human Service Agencies with a Primary Focus on Ten Key Issue Areas," submitted to the Department of Health and Human Resources by the American Public Welfare Association. The states were polled to obtain information about how they are dealing with issues related to the implementation of the new social services block grant. Thirty-three states completed the questionnaire. The study reports some fascinating, if random, facts:

- California has reduced the number of social service programs by 40 percent and has modified 30 percent of those remaining.

- Idaho has identified three major service areas and plans to elminate one in its entirety rather than reduce services in each.

- Colorado is transferring day care for employed AFDC recipients to Title IV-A, and Rhode Island is considering such a shift.

- Iowa, New Hampshire, and North Carolina plan to utilize Title IV-B funds for Title XX service components.

- Providers in West Virginia will be asked to sustain cuts proportionate to departmental cuts.

- On the other hand, Kentucky and North Carolina are cancelling many service contracts.

Random facts notwithstanding, the study's conclusion is clear:

> "The most common and expected trend that appears in the state responses is the emphasis on how the states are absorbing the budget cuts in social services. Few comments are specifically directed at the new block grant mechanism itself."

Who Will Pick Up the Tab?

We must sift through the rhetoric and clearly understand that there are entitlements in this new budget -- entitlements for defense -- and tax breaks (protections) for certain groups. These entitlements are to be financed by disentitling other groups. Thus AFDC, Food Stamps, Medicaid, the Social Services Block Grant, etc. will again be slashed to finance defense and tax breaks.

Earlier philosophies of new federalism were political philosophies which provided sufficient amounts of revenues, collected from citizens, to allow the states to finance programs now funded out of Washington. This brand of new federalism is not a political philosophy. It is a revenue philosophy -- shift costs elsewhere. TIME Magazine describes Senator Charles Percy (R-Ill.) as wondering whether the Administration's real commitment is to new federalism or to budget-cutting; he asked, "Is this a pretext for budget-cutting?"

Will the states pick up the fiscal slack? The answer is a resounding NO. All states, except five, wound up in the red last year. And those few states in the black are refusing to bridge the fiscal gap. Forty-five states are confronting modest to overwhelming deficits.

Will business pick up the slack? C. William Verity, Jr., Chairman of Armco, Inc., and recently appointed chairman of the President's Task Force on Private Sector Initiative, said, "It is unrealistic to expect us to fill what is not just a gap but a chasm." Corporate philanthropy gave $2.3 billion in 1980. If they double their giving to $4.6 billion, they will still be roughly $50 billion short of what the Administration has cut.

Or hear Lindsay H. Clark, Jr. in the WALL STREET JOURNAL, February 2, 1982, "The business of business isn't charity. Most corporations are ill-equipped to do an especially wise job in this area and they know it...President Reagan can't count on a great deal of new help from the corporate community. The conference board survey released last week indicated that companies are unlikely to increase their contributions budget this year to fill the gap caused by cutbacks in Federal spending. Wise companies will keep their eyes on their corporate interests and, for the rest, let their stockholders do their own giving."

Conclusion

Alan Pifer, however, outgoing president of the Carnegie Corporation of New York, is extremely worried about children, "In 1950 there were 16 workers for every Social Security beneficiary... In 1980 the ratio had dropped to 3 to 1. By the year 2010 if there are no changes in the Social Security system, the ratio will be 2 to 1...The nation must do everything in its power to see that today's children, the prime age workers of 20 years from now, get off to the best possible start in life... It is vital that these small cohorts not be depleted even further by casualties...youngsters who never acquire basic literacy, and numeracy skills, whose health is poor, who are malnourished, who are neglected, and who fall into delinquency. If they become casualties, the loss is twofold: they fail to become productive citizens, and they become an additional burden on what will already be an overtaxed generation.

In short, Pifer says that too few will be supporting too many. He exhorts us to think in terms of our national security, not simply in terms of weapons, but in terms of the quality of the nation's human resources, its morale and spirit. Pifer concludes, "the current move to cut the funding of social programs for children seems to me short-sighted and irresponsible in the extreme. Rather than reducing these services we should as a matter of national interest, and if you will of self-interest, be sharply augmenting them" ("The Environment for Human Services in the '80's").

Now I wish to share with you similar thoughts from two unlikely sources. The first quote is from J. Michael Monro, President of Time, Inc.:

> Combined with tax cuts that benefit mostly higher income people, this program adds up to a major redistribution of money in our society from the lower end to the upper end of the scale...The group that concerns me most is children, and families headed by women...We can't afford to let the productive potential of any of today's children languish because of our neglect...They are vital to our future and we should help them get the best possible start in life. That means good schools, good nutrition, health care, housing, and stable homes. Yet we're moving in the opposite direction now and in the foreseeable future. That disturbs me and I think it should disturb you." (NEW YORK TIMES, Sunday, November 15, 1981)

And hear what Norman Miller, chief of the WALL STREET JOURNAL's Washington Bureau has to say,

> "It is fundamentally unfair for the Administration to concentrate almost exclusively on cutting assistance to the poor while simultaneously providing an excessive array of tax breaks to affluent persons and corporations."

The Most Reverend Joseph M. Sullivan, Auxiliary Bishop of Brooklyn said it this way, "The poor have a right to have their minimum needs met before the less basic desires and wants of others are fulfilled." (Testimony before the House Committee on the Budget, February 22, 1982).

Should not this great nation be proud to help support its children, its future? Did this nation not pass the Interstate Commerce Act in 1887 after states had failed utterly to control the sprawling railroads? Did not the government step in to protect the weak, elderly, young, homeless and unemployed during the economic collapse of the 1930's? Would we dream of scrapping our centralized banking mechanism of the Federal Reserve System? Would we scrap our interstate highway system, our western water projects, TVA and protection of basic civil rights?

The League is most worried about government abdication of responsibility for vulnerable children, and a potential state social Darwinism that could tear at this country's vitals.

Is the only role of the Federal government the national defense? Has not this country said that it stands to protect the poorest and the weakest? It must not turn its back on this commitment. The federal government is the moral court of last resort. This country's promise to shield the truly needy and weakest from hostile economic and social conditions is being broken. We are interdependent. If I am frightened by anything coming out of Washington today, I am most frightened by this state Social Darwinism -- the claim that states can and should do it all. No, our society is too complicated for that. Arizona does have a responsibility for the New York subway system, strange as it may sound. For that subway system binds the New York community just as federally supported water projects bind parts of the southwest.

If states alone have to bear the costs of helping low-income families, how will they manage during periods of economic decline or recessions which they cannot control and when the number of people needing help increases as revenues decrease. President Reagan has said that people can vote with their feet. However, I question how poor children and their families unable to obtain the basic necessities in life could secure the additional resources to enable them to move to a more benevolent state. This new federalism, would obliterate the principle of public policy in this country that has existed for longer than the average age of most members of Congress. This principle holds that there are some matters of national interest which must be pursued on a national level, and that there is a national interest in seeing that these matters are successfully pursued. It has been demonstrated that some social problems are so difficult that only the resources of the Federal government can have an impact on them.

It is one thing for states to compete for a formulated share of Federal progam dollars, but it is another matter to vigorously compete with other states and regions for sparse resources. Any state that makes a decision to raise taxes to support the continuation of these programs for children could find itself at a disadvantage with other states which choose to do less because they would likely encourage businesses and individuals to relocate elsewhere.

I sincerely hope that we as a Nation are not wholly self-interested, that we have not lost the notion of the common good, and how absolutely dependent this nation is upon its youngest citizens.

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The Effect of Employment on the Monthly Disposable Income* of AFDC Families: Comparison of FY 1981, FY 1982, and FY 1983

APPENDIX I-A

	FY 1981 Prior to Budget Reconciliation Act			FY 1982 Current Law			FY 1983 Budget Proposals		
	DISPOSABLE INCOME			DISPOSABLE INCOME			DISPOSABLE INCOME		
	Non-Working Parent	Working Parent	Difference**	Non-Working Parent	Working Parent	Difference**	Non-Working Parent	Working Parent	Difference**
ALABAMA	$307	$406	$ 99	$307	$365	$ 59	$301	$347	$ 46
ARIZONA	370	449	79	370	374	4	363	355	– 8
ARKANSAS	311	464	154	311	454	144	305	420	115
CALIFORNIA	584	758	174	584	537	– 47	561	479	– 82
COLORADO	468	601	133	468	477	9	435	424	– 11
CONNECTICUT	563	731	168	563	534	– 29	509	470	– 40
DELAWARE	438	589	151	438	480	42	405	438	33
DIST. OF COLUMBIA	450	616	166	450	499	49	427	453	26
FLORIDA	377	491	114	377	402	25	368	377	10
GEORGIA	362	453	91	362	368	6	351	347	– 4
IDAHO	466	634	168	466	512	46	436	460	24
ILLINOIS	449	590	141	449	459	10	428	420	– 8
INDIANA	419	564	144	419	463	44	398	426	29
IOWA	505	664	159	505	501	– 4	466	450	– 16
KANSAS	467	612	145	467	478	10	445	433	– 13
KENTUCKY	376	522	147	376	470	94	354	432	78
LOUISIANA	366	449	83	366	371	5	356	349	– 7
MAINE	462	649	187	462	526	64	428	464	37
MARYLAND	432	590	158	432	485	54	408	443	35
MASSACHUSETTS	518	685	167	518	511	– 6	478	459	– 19
MICHIGAN	513	675	162	513	532	19	489	482	– 6
MINNESOTA	573	742	169	573	537	– 36	522	472	– 50
MISSISSIPPI	287	504	216	287	442	154	279	410	131
MISSOURI	409	570	161	409	483	74	393	442	49
MONTANA	472	566	94	472	478	6	431	423	– 8
NEBRASKA	500	656	156	500	498	– 2	460	447	– 12
NEW HAMPSHIRE	505	649	145	505	515	10	457	444	– 13
NEW JERSEY	500	661	162	500	497	– 3	466	451	– 15
NEW MEXICO	417	546	129	417	439	22	393	406	13
NEW YORK	537	703	166	537	525	– 12	508	468	– 40
NORTH CAROLINA	369	504	135	369	441	72	357	410	53
NORTH DAKOTA	525	684	159	525	521	– 4	464	464	0
OHIO	422	543	121	422	430	8	403	393	– 10
OKLAHOMA	434	587	152	434	468	34	415	430	15
OREGON	462	628	166	462	496	33	441	451	10
PENNSYLVANIA	465	631	166	465	501	36	439	455	16
RHODE ISLAND	567	720	152	567	567	0	526	502	– 24
SOUTH CAROLINA	334	495	161	334	453	119	316	418	102
SOUTH DAKOTA	478	633	155	478	489	12	441	445	4
TENNESSEE	322	456	134	322	438	116	305	405	100
TEXAS	306	409	104	306	372	66	301	353	52
UTAH	503	629	126	503	511	9	471	460	– 11
VERMONT	596	768	172	596	543	– 53	542	478	– 64
VIRGINIA	417	549	132	417	439	22	398	407	10
WASHINGTON	551	713	161	551	545	– 6	518	485	– 33
WEST VIRGINIA	380	493	112	380	404	24	366	378	12
WISCONSIN	579	750	171	579	537	– 42	539	467	– 72
WYOMING	471	593	122	471	479	8	437	426	– 10
US AVERAGE	$450	$595	$146	$450	$476	$ 26	$423	$432	$ 9

*Disposable income figures shown for each state represent the sum of earnings, AFDC, Food Stamps, EITC, and energy assistance benefits for either a working or non-working family in that state. Earnings are calculated based on the average earnings for an AFDC family in that state.

**All numbers do not add due to rouding

Rise in Federal Costs if Work Effort is Reduced APPENDIX I-B

	Federal Costs for Working Families [1]			Federal Costs for Families No Longer Working [2]		
	AFDC	FOOD STAMPS	TOTAL	AFDC	FOOD STAMPS	TOTAL
ALABAMA	$ 36.4	$160	$196.4	$ 72.8	$183	$255.8
ARIZONA	$ 84.8	$138	$222.8	$109.7	$161	$270.7
ARKANSAS	$ 6.5	$141	$147.5	$ 76	$183	$259.0
CALIFORNIA	$172	$0	$172	$251	$55	$306.0
COLORADO	$105	$90	$195	$145	$122	$267.0
CONNECTICUT	$143	$33	$176	$194	$83	$277.0
DELAWARE	$ 76	$97	$173	$120	$139	$259.0
DIST. OF COL	$ 81.5	$78	$159.5	$143	$127	$270.0
FLORIDA	$ 66.6	$127	$193.6	$108.6	$159	$267.6
GEORGIA	$ 76.9	$141	$217.9	$108.8	$168	$276.8
IDAHO	$104.7	$65	$169.7	$179.8	$122	$301.8
ILLINOIS	$ 95.5	$91	$186.5	$145	$126	$271.0
INDIANA	$ 73.2	$105	$178.2	$124	$143	$267.0
IOWA	$118.4	$65	$183.4	$167	$106	$273.0
KANSAS	$106.5	$83	$189.5	$158	$117	$275.0
KENTUCKY	$ 45.7	$124	$169.7	$108.8	$166	$274.8
LOUISIANA	$ 87.2	$142	$229.2	$115.0	$166	$281.0
MAINE	$134.6	$70	$204.6	$178.8	$127	$305.8
MARYLAND	$ 73	$92	$165	$126.5	$138	$264.5
MASSACHUSETTS	$121.5	$49	$170.5	$176	$99	$275.0
MICHIGAN	$143.5	$54	$197.5	$192	$94	$286.0
MINNESOTA	$149	$23	$172	$205	$76	$281.0
MISSISSIPPI	$ 55.3	$126	$181.3	$ 57.2	$183	$240.2
MISSOURI	$ 67.2	$97	$164.2	$133.2	$145	$278.2
MONTANA	$149.4	$103	$252.4	$168.5	$125	$293.5
NEBRASKA	$122.4	$69	$191.4	$171.1	$110	$281.1
NEW HAMPSHIRE	$126.8	$77	$203.8	$169.7	$111	$280.7
NEW JERSEY	$115	$63	$178	$168.5	$106	$274.5
NEW MEXICO	$ 95.3	$111	$206.3	$145.5	$145	$290.5
NEW YORK	$143	$40	$183	$204.5	$84	$288.5
NORTH CAROLINA	$ 55.9	$126	$181.9	$117.5	$165	$281.5
NORTH DAKOTA	$134.3	$66	$200.3	$177.8	$107	$284.8
OHIO	$ 86.2	$109	$195.2	$125.3	$140	$265.3
OKLAHOMA	$ 92.1	$91	$183.1	$149.7	$133	$282.7
OREGON	$ 92.5	$72	$164.5	$154	$120	$274.0
PENNSYLVANIA	$ 94.1	$73	$167.1	$155.9	$121	$276.9
RHODE ISLAND	$178.9	$40	$218.9	$226.7	$74	$300.7
SOUTH CAROLINA	$ 37.1	$134	$171.1	$ 74.1	$183	$257.1
SOUTH DAKOTA	$129.9	$79	$208.9	$189.4	$120	$309.4
TENNESSEE	$ 15.6	$149	$164.6	$ 68.3	$183	$251.3
TEXAS	$ 26.4	$159	$185.4	$ 57.4	$183	$240.4
UTAH	$176.2	$76	$252.2	$224.9	$104	$328.9
VERMONT	$205.4	$4	$209.4	$286	$65	$351.0
VIRGINIA	$ 79.5	$108	$187.5	$125.7	$143	$268.7
WASHINGTON	$155.5	$40	$195.5	$211	$78	$289.0
WEST VIRGINIA	$ 79.8	$128	$207.8	$125.5	$160	$285.5
WISCONSIN	$169.1	$11	$180.1	$240.1	$66	$306.1
WYOMING	$111.5	$93	$204.5	$145	$122	$267.0
			Average: $189.8			Average: $279.4

[1] Prior to the Budget Reconciliation Act of 1981

[2] Under the new FY 1983 proposals

APPENDIX II-A

FEBRUARY 1982

child welfare league of america, inc.

CHILD WELFARE SERVICES, FOSTER CARE, AND ADOPTION ASSISTANC FUNDING LEVELS

(in millions - some figures are rounded)

	Title IV-B Services	Title IV-E/A AFDC-Foster Care	Title IV-E Adoption Assistance	Total	Percent Reduction from P.L. 96-272 Recommendations
P.L. 96-272 Expectation FY '81	$163.55[a] regular appropriation	$349 capped	$10 entitlement	$522.55	0
P.L. 96-272 Appropriation FY '81	163.55 regular appropriation	349 capped	10 entitlement	522.55	0
P.L. 96-272 Expectation FY '82	220 advanced funded	395 capped	10 entitlement	625	0
P.L. 96-272 Appropriation FY '82	153.326[b] not advanced funded	299 entitlement (345.9)[c]	5 entitlement	460.326 (504.226)[c]	26% (19%)[c]
P.L. 96-272 Expectation FY '83	266 advanced funded	434.5 capped	10 entitlement	710.5	0
Administration's FY '83 Proposed Child Welfare Block Grant	REPLACED BY NEW TITLE IV-E CHILD WELFARE BLOCK GRANT ALSO INCLUDES CHILD WELFARE TRAINING PROGRAM[d] Repealed	Amended no entitlement	Amended no entitlement	380.123	47%

(a) IV-B funding scheduled to shift to advanced funding mechanism in FY '81 for FY '82, and thereafter, appropriations.
(b) H.H.S. has cut approximately 4½% from IV-B appropriation level of $163.55 million.
(c) Supplemental appropriation will be required; CBO estimates $345.9 million will be needed to meet foster care expenditures.
(d) Child welfare training program funded at $5.2 million in FY '81 and $3.823 million in FY '82.

NOTE: FY '83 BLOCK GRANT PROPOSAL CUTS $124.103 MILLION (25%) FROM FY '82 FUNDING LEVEL, BASED ON ENTITLEMENT.

APPENDIX II-B

child welfare league of america, inc.

COMPARISON OF P.L. 96-272 FULL IMPLEMENTATION FUNDING LEVELS WITH ADMINISTRATION'S CHILD WELFARE BLOCK GRANT PROPOSAL

(in millions - some figures are rounded)

	P.L. 96-272 Expectation(1)	Administration's Child Welfare Block Grant(2)	Percent Cut(3)	Dollars Cut(3)
FY '83	$710.5	$380	47%	$334.2
FY '84	$753.95	$380	50%	$377.6

1) Based on scheduled increases in IV-B child welfare services; IV-E foster care at anticipated capped levels; and assumed only $10 million for IV-E adoption assistance entitlement program. DOES NOT INCLUDE CHILD WELFARE TRAINING PROGRAM.
2) Authorization level; therefore, a lesser amount could be appropriated. Child welfare training program included ($3.823 million in FY '82).
3) Child welfare training funds factored into cut.

CUMULATIVE LOSS OF FUNDING TO IMPLEMENT P.L. 96-272 REFORMS UNDER CURRENT TITLE XX BLOCK GRANT AND ADMINISTRATION PROPOSED CHILD WELFARE BLOCK GRANT

(in millions)

	FY '82 Title XX Dollars Cut	Proposed Child Welfare Block Grant Cut	Cumulative Loss
FY '83	$749	$334.2	$1,083.2
FY '84	799	377.65	1,176.65

CUMULATIVE LOSS OF FUNDING TO IMPLEMENT P.L. 96-272 REFORMS UNDER ADMINISTRATION PROPOSED FY '83 BUDGET FOR TITLE XX AND CHILD WELFARE BLOCK GRANT

(in millions - some figures are rounded)

	Proposed Title XX Dollars Cut Since August 1981*	Proposed Child Welfare Block Grant Cut	Cumulative Dollar Loss
FY '83	$1,225	$334.2	$1,559.2
FY '84	1,325	377.65	1,702.65

* Does not include funding loss due to zero budget in FY '83 for WIN programs which may be provided under Title XX (WIN funded at $365 million in FY '81, $256 million in FY '82).

APPENDIX III

child welfare league of america, inc.

TITLE XX BLOCK GRANT FUNDING LEVELS*

(in billions - some figures are rounded)

	Statutory Ceilings in 1980 Child Welfare Act (P.L. 96-272)	Final FY'82 Budget Reconciliation Levels	Percent Cut	Dollars Cut
FY '82	3.099*	2.4	23%	.699
FY '83	3.199	2.45	23%	.749
FY '84	3.299	2.5	24%	.799
FY '85	3.399	2.6	24%	.799

* CBO FY '82 baseline data

COMPARISON OF CURRENT TITLE XX FUNDING LEVELS WITH FY '83 ADMINISTRATION BUDGET

(in billions - some figures are rounded)

	FY '82 Budget Reconciliation Level	FY '83 Administration Proposed Level*	Percent Cut	Dollars Cut
FY '83	$2.45	$1.974	20%	$.476
FY '84	2.5	1.974	21%	.526
FY '85	2.6	1.974	24%	.626

* Assumes Administration would continue to fund at FY '83 level. However, Administration is likely to propose futher cuts in the future.

NOTE: ADMINISTRATION PROPOSES THAT TITLE IV-C WORK INCENTIVE PROGRAMS (WIN) OR WIN DEMONSTRATION PROGRAMS MAY BE PROVIDED FOR UNDER TITLE XX PROGRAM ALTHOUGH NO ADDITIONAL REVENUES WOULD BE PROVIDED. WIN PROGRAM FUNDED AT $365 MILLION IN FY '81 AND $265 MILLION IN FY '82; FY '83 BUDGET REQUEST IS ZERO.

CUMULATIVE LOSS OF TITLE XX FUNDING SINCE AUGUST 1981

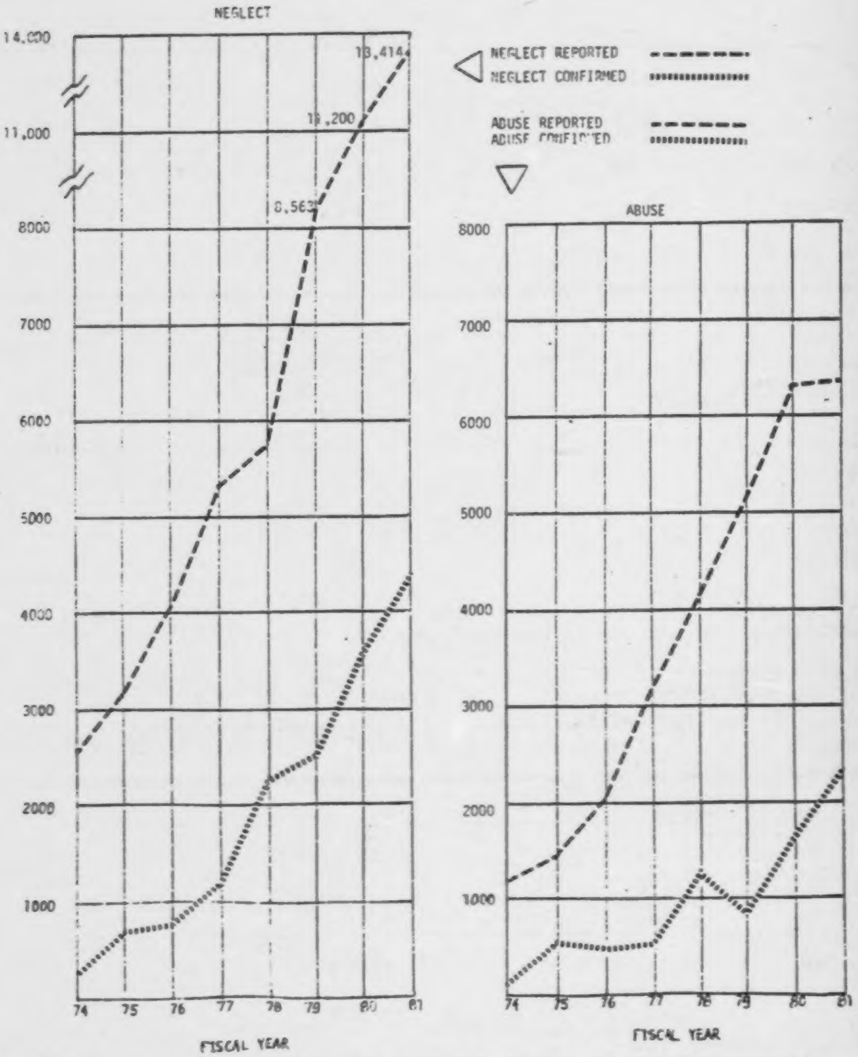
(in billions)

	FY '81 Statutory Ceilings	FY '82 Statutory Ceilings	FY '83 Administration Budget	Total Percent Cut	Total Dollars Cut
FY '83	$3.199	$2.45	$1.974	38%	$1.225
FY '84	3.299	2.5	1.974	40%	1.325
FY '85	3.399	2.6	1.974	42%	1.425

* Does not include funding loss due to zero budget for WIN programs in FY '83 and thereafter (WIN funded at $365 million in FY '81, $256 million in FY '82).

APPENDIX IV

CHILD ABUSE/NEGLECT REPORTED AND CONFIRMED FROM 1974-1981 BY FISCAL YEAR



Source: Services to Children and Youth, Social Services, Department of Social and Rehabilitative Services, Annual Report, 7/1/80 through 6/30/81, submitted November 1981.

PREPARED STATEMENT OF MISS JANE RUSSELL, FOUNDER, WAIF, INC.

To the Members of the Senate Finance Committee:

In the past year, I have met with several of you personally and corresponded with most of you. I testified before the House Subcommittee on Public Assistance and Unemployment Compensation last year regarding The Adoption Assistance and Child Welfare Act, P.L. 96-272.

If there were any possible way that I could appear before you today, I would be there. Some rather complicated and long-standing scheduling conflicts do not allow that to be the case. I am, therefore, grateful to have the opportunity to submit these written remarks and hope to meet with you in the near future.

As you know, I am an actress. But I've spent almost 30 years in another far more rewarding career. I am a child advocate; I have three adopted children and I am the Founder of WAIF, an organization dedicated to finding permanent and loving families for homeless children. I serve on the National Board of WAIF and have served on the California Adoption Commission. In my efforts to preserve Public Law 96-272 and get kids back into families, WAIF and I work in association with the Child Welfare League of America.

I will leave the arguments about entitlements, acts and titles to the experts. I'm writing to argue for children's lives and the quality of those lives. I write on behalf of 500,000 kids now in foster care, many of whom are desperately in need of permanent, loving families.

WAIF is a non-profit, voluntary organization with thousands of supporters in every state across the country. We are completely financed by private donations. WAIF is not made up of professional social workers. We are concerned volunteer citizens. WAIF seeks families for children and not children for families. The child is our client. The child is the one in need.

We are concerned about American kids who are denied the opportunity to grow up in a nurturing family because they are the victims of a child welfare system headed in the wrong direction.

I agree with President Reagan on the need to reduce the power of nameless, faceless bureaucracies over our lives. I agree with the President that we must do all we can to lower public spending. I agree with the President and the Republican Party Platform that we should do everything in our power to encourage and support the American family.

It is because I agree with these principles that I support Public Law 96-272. P.L. 96-272 -- reduced to a few letters and a string of numbers it sounds like all the other bits from the Washington alphabet soup. Spell out the name -- The Adoption Assistance and Child Welfare Act of 1980 -- and you can understand why I'm concerned. You have to take a little time to understand what the act is all about to see why it is worth keeping, why it shouldn't be tossed into the same meat grinder with all the other programs being cut back.

In 1962 I told state legislators we had to either put families back together or remove the road blocks to adoption, that foster care should only be temporary. Nineteen years later you finally came up with a concrete plan. A program that's headed in the right direction; that either keeps families together by providing supportive services to strengthen and reunify the family or creates a new one through adoption. This program provides incentives for adoption, and puts limits on the amount of money poured into the foster care system by linking foster care funds to the dollars spent on services to kids and their families. Spending a few extra bucks on kids now will build workable alternatives to foster care, and save money in the long run.

It's a law everyone can support because, instead of just throwing money at a problem it says: here, this is what we can do to lick this problem and save our kids.

If the money for this program were to be put into a block grant, it would go to 50 states who can't even agree on adoption laws. Some states are 50 years behind the times. We'd have 50 different halfway measures -- instead of one plan that's already proved miraculous. A plan that gets kids out of limbo and off the taxpayers back.

One of the problems we've had in getting children released for adoption has been with the courts. Judges simply can't spend the time for an in-depth examination of each child. Social workers do their work; the parents come into court and cry a little; the judge thinks blood is thicker than water and the child goes back into limbo. In Arizona, my new home for the past two years, the judges and legislators recognized this problem and developed an amazingly effective foster care review board. It, incidentally, is similar to the mandatory review in P.L. 96-272. Here's how it works.

A review board involving 200 members, broken into 40 review boards representing every county in Arizona, donated 7,000 hours and reviewed 5,610 children in 1981. They dismissed out of the system 683 cases involving 909 children for adoption or return home to their own families (or because the child turned 18, was married, or emancipated earlier). The review board, coupled with other permanency planning initiatives, played a significant role in moving children through the system. Because of this success, Arizona serves as a model review system for the entire nation for finding permanent placements for children. It truly shows what can be accomplished with P.L. 96-272.

Do away with the law and we're right back where we started: warehousing kids as if they were spare tires, or boxes of shoes. Maybe losing them altogether when their records get shuffled into the wrong file. As we lose them now, when officials who placed them don't know where they are. We throw what little money we have in the general direction of the problem and then wonder why it doesn't do much good.

It makes no sense to spend millions on a system no one is happy with, a system that no one thinks works very well. When what is being wasted is children, the waste isn't simply bad business, it's criminal.

The Administration's proposed block grant just doesn't work. They've taken some of the language and thrown out the mandates for change, including the money. I'm not just talking about programs -- I'm talking about changes in children's lives. They've removed the entitlements to get kids into adoptive homes. The specifics are gone; most of the already-limited money is gone; the state plans are gone, and once more kids are victims of the system. And they stand to lose badly. The states will not be able to reform their systems without the money and the guidance of this legislation crucial to children.

I am not against the concept of states' rights. But I'm more strongly in favor of children's rights. Under the block system, those rights will never be fulfilled.

And let's look at the current state-run systems. The fact that 500,000 children remain in foster care instead of being returned to their restrenghtened families or cut loose for adoption indicates to me that those state systems just don't work. The states and the children need Public Law 96-272 and adequate funding to implement it.

I beg you to maintain P.L. 96-272 as current law and retain the funding for it and the programs which support it, such as the Title XX Social Services Block Grant.

Thank you for the opportunity to present my views.

STATEMENT OF ELLEN HOFFMAN FOR MARIAN WRIGHT EDELMAN, PRESIDENT, CHILDREN'S DEFENSE FUND, WASHINGTON, D.C.

Ms. HOFFMAN. Thank you.

Mr. Chairman, my name is Ellen Hoffman, and I am the director of governmental affairs for the Children's Defense Fund. I apologize for Marian Edelman, who is ill this morning and unable to appear at the last minute.

I appreciate the opportunity to testify on a range of proposals for children's programs in the President's fiscal 1983 budget.

CDF is a national public charity created to provide systematic and thoughtful advocacy on a number of issues that affect children and families. We believe, and we have stated in our so-called "Green Book" A Children's Defense of the Budget: An Analysis of the President's Budget and Children, that the budget battle this year is a battle for a fair and decent America. It is a battle about whether we will continue to invest Federal dollars in the young, in families, in the needy, and in working men and women, or whether we will invest in the rich and in more and more arms and more and more tax breaks which lead us down a path of economic and moral bankruptcy. It is a battle about whether we will invest in human capital or whether we choose short-term profit and easy political fixes.

We have done, in our budget analysis, a study which found that a group of critical children's programs were cut by $10 billion in fiscal 1982. The President has proposed to cut an additional $8 billion in this selected group of programs in fiscal 1983.

There are a broader range of programs affecting poor, handicapped and homeless children and their families which would suffer up to $27 billion cuts in fiscal 1983 alone if they were adopted as proposed by the President.

I would like to use my time this morning to make some four key points and to say, first of all, that Children's Defense Fund endorses everything that has been said just before me by the other witnesses with regard to the Child Welfare and Adoption Assistance legislation which was enacted through this committee and which the President has proposed be block-granted.

Specifically, though, there are some general points I would like to make about the proposed fiscal year 1983 cuts.

One is that entitlement policy decisions and budget cuts have a particularly severe impact on children. Of all AFDC recipients 68 percent are children. Half are 8 years old or younger, and the remaining 3½ million adult recipients are primarily sole parents living with children and single parent families.

Half of the 22 million food stamp recipients are children, and children make up nearly half of the recipients of medicaid. The children on medicaid are the poorest of the poor. Income standards for mothers and children applying for medicaid have lagged far behind those for the elderly and disabled. For example, between 1975 and 1980 the amount of income a mother and child in Massachusetts could have and still qualify for medicaid rose by 5 percent, while the amount of income that an aged or disabled adult could have and still qualify rose by 26 percent.

We have found, in trying to assess the impact of last year's cuts and legislative changes in terms of some of these fundamental children's survival programs, that some 660,000 children are likely to be cut nationally from the AFDC program, that in Ohio where we have a field office some 14,000 families including 3,000 children will be turned off the AFDC program. In Mississippi, where we also have an office, 9,000 of the 12,000 part-time working families who are on AFDC are also likely to be cut.

The second point I would like to make is that the key programs on which children depend for survival—AFDC, food stamps, and medicaid—were already cut to the bone last year; $3.9 billion was taken out of those programs alone, and they cannot afford another cent more.

The cuts in social services and child care, and there is an estimate that 150,000 children will be knocked out of title XX child care programs alone, were particularly short-sighted, because many of these cuts created disincentives to work for families who want to work, and many cheated the children and families of preventive services which are so crucial to avoiding long-range human and economic costs of institutionalization and dependency.

The third key point this morning is that policy and budget decisions on entitlements and the family support services in your jurisdiction are interrelated, and they create a variety of ripple effects. It is, therefore, very important to consider these interrelationships in making decisions.

For example, a decision to cut AFDC eligibility is in 20 States a decision to foreclose a sick child's access to a doctor through medicaid.

With regard to medicaid, there is one key comment that we would like to make in terms of the proposals from the administration. We know that this committee is seriously contemplating allowing States to impose cost sharing on certain additional medicaid services. We would ask that you exempt health services for children and pregnant women from any copayments.

While children make up almost half of the medicaid population, they do not consume health services that are busting the medicaid budget. Copayments will cut down on utilization rates, and the impact of this will be particularly severe on pregnant women and children, with very serious long-term effects.

In conclusion, I would like to say that there were choices before the Congress and the American public last year, and we have choices again this year about the decision that we make. We are very pleased that the Chairman and others in the Senate have been proposing alternative sources for revenue-raising and alternative cuts in the budget. We would urge that you keep in mind that it is not true that the only sector of the budget which can be cut is social programs, that it is time for us to examine with equal rigor all the segments of the Federal budget, to look at our tax system again, and to determine what are the policies which will be strengthening and supportive of families and not stimulate more dependency over the long run.

Thank you.

[The prepared statement of Ms. Edelman follows:]

TESTIMONY OF MARIAN WRIGHT EDELMAN, PRESIDENT
THE CHILDREN'S DEFENSE FUND
U.S. SENATE FINANCE COMMITTEE
MARCH 16, 1982

Mr. Chairman and Members of the Committee: I appreciate the opportunity to testify this morning on a range of proposals for children's programs in the President's fiscal 1983 budget.

CDF is a national public charity created to provide systematic and thoughtful advocacy on a number of issues that affect children and families. Over the years, CDF has produced lengthy reports on major health, social services, and education programs affecting children. In each instance, we have not only reported on the successes or failures of each program, but have also sought to develop a careful and responsible agenda for reform that would help redirect public policies and public funds in a more effective fashion.

The budget battle this year is a battle for a fair and decent America. It is a battle about whether we will continue to invest federal dollars in the young, in families, in the needy, and in working men and women or whether we will invest in the rich and in more and more arms, which leads us down the path of economic and moral bankruptcy. It is a battle about whether we invest in human capital--or whether we choose short-term profit and easy political fixes. It is a battle about who and what we Americans are as a people and as a nation.

It is our strong view as a Children's Defense Fund (CDF), based upon the unfair impact of the FY 1982 Budget and the faulty premises underlying the FY 1983 Budget, that not another dime should be taken from programs for poor, handicapped, sick, and homeless children or their families. Nor should another minute be diverted into a "New Federalism" debate when 9-1/2 million Americans are out of work and millions of others are going without the basic necessities of food, energy, housing, and health care.

There may indeed be a time for a thoughtful federalism debate; but this is not it. The Reagan proposals cannot be tinkered with, refined, or fleshed out. They should simply be rejected as unjust and unworkable. Their goal is not to help people or to increase government effectiveness, but rather to cut dollars without regard for human consequences.

We have just published A Children's Defense Budget: An Analysis of the President's Budget and Children. In it we have tried to assess the impact of the budget cuts and program changes made last year on children and families; and to provide a realistic assessment of what the new Reagan proposals would do to the most vulnerable groups--children, the poor, minorities, the handicapped--in our society.

We found that a group of critical children's programs were cut by $10 billion in FY 1982. President Reagan is proposing to cut an additional $8 billion in FY 1983. This includes a one-third cut in Title I, the education program for disadvantaged children; a one-fifth cut in child welfare programs which provide homes for homeless children; a one-fourth cut in job corps and youth employment programs; and almost $5 billion in AFDC, Food Stamps and Medicaid.

If we look at a broader range of programs that affect poor, handicapped and homeless children and their families proposed reductions total a massive $27 billion in FY83 alone. This includes $22 billion in new FY 1983 cuts and a proposed $5 billion in rescissions from enacted FY 1982 budget levels. (Attachments A and B summarize these cuts.)

Mr. Chairman, I'd like to use my time this morning by making four key points:

1. Entitlement policy decisions and budget cuts have a particularly severe impact on children. Sixty eight percent of all AFDC recipients are children. Half are eight years old or younger. The remaining 3.5 million adult recipients are primarily sole parents living with children in single-parent families.

   Half of the 22 million Food Stamp recipients are children; and children make up nearly half of the recipients of Medicaid. These children on Medicaid are poorest of the poor.

   Income standards for mothers and children applying for Medicaid have lagged far behind those for the elderly and disabled persons. For example, between 1975 and 1980, the amount of income a mother and child in Massachusetts could have and still qualify for Medicaid rose by 5 percent, while the amount of income an aged or disabled adult could have and still qualify rose by 26 percent.

2. The key programs on which children depend for survival---AFDC, Food Stamps and Medicaid--were cut to the bone last year. $3.9 billion was taken out of these programs alone. They cannot afford another cent more. The cuts in social services, and child care, were particularly short-sighted in that many of these cuts created disincentives to work for families who want to work; and cheated children and families of preventive services so crucial to avoiding long-range human and economic costs of institutionalization and dependency.

3. Policy and budget decisions on entitlements and the family support services in your jurisdiction are inter-related and create a variety of ripple effects. For example, a decision to cut AFDC eligibility is, in twenty states, a decision to foreclose a sick child's access to a doctor through Medicaid.

4. We had choices last year and we have them this year. Despite the administration's attempt to suggest that the only sector of the budget which can be cut is social programs, we all know that tax subsidies for the most prosperous individuals and corporations in our society, and defense expenditures, have never been scrutinized with the same rigor that has been applied to social programs.

We are very aware, Mr. Chairman, that you and others have been examining our tax policies and seeking ways to create a fairer balance among the choices that face us this year. We have also tried to do this in CDF's budget analysis, which contains some $30 billion in alternative budget cuts which could be implemented without jeopardizing our national security. Many of these alternatives are tax measures and are within the jurisdiction of this committee.

The rest of my written testimony consists of an analysis of the effects of the FY82 cuts and proposed FY83 cuts on a range of children's programs--AFDC, Medicaid, Child Welfare, Foster Care and Adoption Assistance, and Social Services, particularly child care.

AID TO FAMILIES WITH DEPENDENT CHILDREN
(AFDC)

I would first like to address briefly the impact of already enacted and proposed cuts in the AFDC Program on the children and working families depending on this program for basic survival.

I would like to emphasize three points to this Committee regarding AFDC.

First: AFDC children are desperately needy and have already been severely hurt by the AFDC program's failure to keep up with inflation.

Aid to Families with Dependent Children (AFDC) is the only program explicitly aimed at protecting poor children by giving their families basic income support. Sixty-eight percent of all AFDC recipients, or over 7 million persons, are children. Half are white. Half are eight years old or younger. The remaining 3.5 million adult recipients are primarily single parents living with children. One out of every eight children is depending on AFDC for survival right now. One out of four will depend on AFDC at some point in their lives.

In most states AFDC benefits are intolerably low, failing to provide even a minimum level of decency. Twenty-two states provide maximum benefits of less than $285 a month, (less than 50 percent of the poverty line), to a mother and two children with no other income. In Mississippi, the average payment for a child is $.99 a day or $30 per month; in Texas it is $1.19 per day or $36 a month. The nationwide high is $4.21 per child per day. States set these benefit levels. By contrast, the average monthly payment for a disabled child under the SSI program, where federal law sets benefit levels, is $7.35 per day or $229 per month.

According to a recent report by the Center on Social Welfare Policy and Law, even when minimal AFDC benefits are combined with Food Stamp benefits the levels in all states but Alaska fall short of even the meager poverty level, and in over half the states they are less than 76 percent of the poverty level. Only six states provide AFDC benefits that bring the combined AFDC/Food Stamp benefit level to 90 percent or more of the poverty level.

The harm to individual children is intensified by the fact that AFDC recipients get no automatic cost of living increases, and state AFDC payments have generally not kept pace with inflation. The average AFDC recipient now gets $3.27 per day, a decrease from the comparable $3.85 per day in 1976, when cost of living is taken into account. Between 1976 and 1980 the average AFDC child lost--in purchasing power--over one dollar out of every eight received from AFDC.

Between 1975 and 1981, according to the same study by the Center on Social Welfare Policy and Law, the gap between benefits and the poverty level grew significantly wider because benefit levels almost uniformly failed to keep pace with cost-of-living increases. During this period the official poverty level increased by approximately 67 percent while the Consumer Price Index rose 73.4 percent. AFDC benefit levels in thirty-three states increased by less than 40 percent, and in 13 of these states benefit levels increased by less than 10 percent. In fact, in two states, Arkansas and Oregon, benefit levels decreased below 1975 levels.

Examples for individual states highlight disparities between increases in benefit levels and increases in the poverty levels:

- Between 1975 and 1981, AFDC benefit levels for a family of three with no other income increased less than 5 percent in eight states, Arkansas, Idaho, Kentucky, North Carolina, Oregon, Texas, Virginia, and West Virginia.
- In the state of Texas, the current benefit level of $118 a month has only increased $2.00 or 1.72 percent since 1975. Even when Food Stamps are added the combined benefit level is only 51 percent of the federal poverty level.

Second: The FY 1982 changes in the AFDC Program devastated children and parents trying to work their way out of poverty.

Federal funds for the $8 billion AFDC Program were slashed by slightly over $1 billion in FY 1982. Combined with state matching funds, this resulted in a reduction of almost $2 billion in money available for income supports to poor children and their families. Congress adopted virtually all of the Administration's proposals for changes in the program, although some proposals were made optional for states instead of mandatory. The AFDC changes adopted include a number that jeopardize children and penalize the working poor -- the very people the Administration announced it wanted to help.

The Department of Health and Human Services itself estimated that at least 660,000 families, including over 1 million children, were expected to lose AFDC or to receive reduced benefits as a result of the cuts. In about half the states, over one out of every five AFDC families was expected to be hurt by the changes.

Individual states are just now beginning to gather specific data on the impact of the implementation of specific changes in the AFDC program on recipients in their states and counties. The state of Ohio, for example, has recently documented through a case-by-case review of its 210,819 Aid to Dependent Children (ADC) cases, that the federal changes in the ADC program have directly affected 71,238 individuals in the state, approximately two-thirds of them children. Over 14,000 families have been removed from the rolls, and almost 3,000 families seeking to establish ADC eligibility have had benefits denied. In Ohio, these families, like families in 19 other states who lose ADC, will also lose their Medicaid eligibility. It is also pertinent that in Ohio, a state faced with an increasing unemployment rate, over 25 percent of the terminations and reductions were attributable to the ADC changes most likely to affect working families.

In the state of Mississippi, since October 1, 1981, 9,000 of the state's 12,000 AFDC mothers who were working at least part time have been cut from the AFDC rolls. Their 20,000 children have lost eligibility for Medicaid and are being denied basic health services. In California it is estimated that 122,000 cases, often including a mother and two children, will lose their AFDC benefits, and 329,000 will receive reduced benefits. Over half of those who are terminated will be cut off because their income exceeds 150 percent of the state's standard of need, $506 a month for a family of three with no other income.

The following specific changes are among those that have resulted in hundreds of thousands of families nationwide being cut from the rolls:

- Families are now ineligible for AFDC if their gross income, including earned income excluded under the earned income disregards, exceeds 150 percent of the standard of need in the state where they live. All states have standards of need that fall well below the poverty line. In fact, in many states an income equal to 150 percent of the standard of need would still be below the poverty line. In states like Mississippi, mothers with two children working more than 23 hours a week at the minimum wage are ineligible for AFDC because of the 150 percent cap.

- First time pregnant women are only eligible for federally reimbursed AFDC beginning in their sixth month of pregnancy. No federal assistance will be provided for benefits for the unborn child. As of October 1, 1980, 29 states provided AFDC coverage to first time pregnant women prior to their sixth month of pregnancy, many of them from the point pregnancy was medically verified. At least 12 states also covered the unborn child. Although some states have chosen to continue to assist these women pregnant for the first time with state funds, others have dropped coverage.

- A stepparent's income must now be counted as income available to an AFDC child -- even if it is not -- in determining AFDC eligibility and benefit levels. Previously states could not count a stepparent's income as available to a child unless the stepparent was actually contributing to the child's support or under state law had a legal obligation to support the stepchild. This change has resulted in Ohio, for example, in terminations or reductions in benefits for over 58,000 families, including over 100,000 children.

  Such a provision may encourage the breakup of intact families. For purposes of AFDC eligibility and payments a child may be presumed to be receiving support from a stepparent when in fact he or she may be receiving nothing. In such cases a mother might in fact be better able to care for her children living apart from her husband.

Third: This year's proposed changes in the AFDC Program cut deeper into the working poor, reduce state flexibility in administering work requirements, and hit hardest at the poorest of the poor.

We have three basic concerns about this year's proposed changes:

- they penalize the poorest of the poor;
- they attack children and families under the rubric of "administrative" savings; and
- they further discourage families struggling to work their way out of poverty.

As if AFDC children have not already given enough, this year the Administration seeks an additional $1.2 billion in AFDC cuts for FY 1983, a real cut of over $2 billion when loss of state matching funds is included.

1. The changes proposed for FY 1983 hit hardest at the poorest of the poor, removing any vestiges of the Administration's "safety net." AFDC families already live from crisis to crisis. As mentioned earlier, in most states AFDC payments are intolerably low, failing to provide even a minimum level of decency. Any extra need beyond a family's control -- a high utility bill in an unusually cold winter, a fire in the apartment, or theft of a family's belongings -- creates a crisis that the AFDC grant is simply inadequate to meet.

The Administration is proposing to eliminate the "safety net" programs Congress has established to help cushion the impact of these emergencies by:

- eliminating the Emergency Assistance program. At their option, states can currently provide emergency assistance once a year to families in crisis (for example, paying for replacement bedding if the family has lost its furniture in a fire). Half the states now participate. This program would be abolished, and the only way states could provide emergency assistance would be through a "broadened" energy assistance program -- which the Administration proposes to cut by $565 million in FY 1983.

- requiring that part of the value of low income energy assistance grants be counted as income in determining a family's AFDC benefits. Low income energy assistance grants were established to meet the emergency needs of the poor, whose ordinary income, including AFDC grants, was inadequate to meet the soaring costs of heat and electricity. Just last year, natural gas, the primary heating source for low income people, increased in cost by twenty percent. AFDC grants did not. Between 1980-81, five states actually lowered their benefits. Michigan recently joined their ranks. In many other states grants have remained at previous years' levels. By requiring that low income energy assistance be offset, the basic goal of the energy assistance program, to help poor people whose income cannot keep pace with inflation in energy costs, would be defeated.

Without these two safety net programs, it is difficult to know how AFDC families can meet family crises with dignity and health.

Moreover, the Administration is proposing to penalize the poorest of AFDC families by depriving them of the benefit of any economies they may be able to achieve. The Administration proposes to reduce shelter and utility allowances to AFDC families who have chosen to share housing with other families, based on the Administration's assumption that they no longer need the full amount of shelter and utility assistance available to a family of their size. In fact, the opposite is often the case: welfare families often share housing space precisely because the current full grant for housing and utility costs, which virtually no state has adjusted to reflect inflation, is inadequate to provide even minimally safe and decent housing without sharing space with other families. In Dallas, for example, the average cost of a two-bedroom apartment is $250 per month. The maximum AFDC grant for a family of four in Texas is $141 per month. By proposing to reduce shelter costs for families who share space, the Administration penalizes those families who are least able to afford separate housing. And it penalizes parents desperately trying to economize in one area in order to stretch their check to meet children's needs in others -- for clothing, food, furniture, school supplies, or transportation.

Poor families have already given enough without being forced to donate their safety net to this year's budget.

2. Even budget cuts described by the Administration as "administrative savings" in the AFDC program will have a devastating effect on poor families. These proposed changes include:

- requiring states to round benefits to the lower whole dollar. Presently, states can "round up," giving families the benefit of the doubt when grant calculations come out to a dollar and change.
- prorating the first month's benefit based on date of application.
- reducing federal matching funds for erroneous benefit payments. States will be penalized by loss of federal matching funds for errors in excess of 3 percent of their AFDC caseload. By 1986, they will be expected to have a zero error rate.
- combining administrative costs for AFDC, Medicaid, and Food Stamps.

While these savings are described as administrative, again those who bear their brunt would be children and families. Meager benefit levels would be severely threatened by fiscal pressures on state budgets that would be caused by these proposed administrative changes.

Some of the changes also directly penalize families at a time when they are most in need -- for example, the requirement that states prorate the first month's benefit based on date of application. States are now allowed to pay benefits back to the first day of the month of application. Under this proposal, states would be required to give a partial grant for the first month, prorated to reflect the date of application, even though a family may have been without income for the entire month and desperately needs a full month's grant.

3. The proposed cuts further penalize families struggling to work their way out of poverty. The Administration proposes to mandate workfare programs rather than to leave implementation of such programs to state option. At the same time, the Administration proposes to eliminate funding for the Work Incentive Program (WIN), the only present source of job counseling, training, placement, and support services for AFDC recipients struggling to find permanent employment. The workfare proposal limits states' flexibility to design work programs that best meet their recipients' needs: last year's amendments gave states the option of choosing among three new work-related options and the current WIN program. This proposal would limit that flexibility the Administration thought so important last year. At the same time, it would do away with the funding for services many recipients need in order to become self-supporting.

HEALTH

This section addresses the proposed cuts in the Medicaid program, which will have a substantial impact on children, and the proposed consolidation of the Supplemental Food Program for Women, Infants, and Children (WIC) with the Maternal and Child Health Block Grant.

MEDICAID

First: Every cut in the federal Medicaid budget is a direct blow to the 11 million children who depend on Medicaid to pay for essential health services.

Children, more than any other age group, rely on Medicaid to pay their medical bills. Unlike older Americans they do not have Medicare or private insurance policies. In 1979, 55 percent of public dollars paying for children's health care were spent through Medicaid, which accounted for only 28 percent of public health funds spent on other age groups.

Although persons eligible for Medicaid are poor, children eligible for Medicaid benefits are the poorest of the poor. For example, in Texas, an elderly person living alone can have income of $286 per month and qualify for Medicaid. A mother and three young children, however, can have income of no more than $140 ($35.00 per family member) to qualify for Medicaid.

Income standards for mothers and children applying for Medicaid have lagged far behind those for the elderly and disabled. For example, between 1975 and 1980, in Massachusetts the amount of income a mother and child could have and still qualify for Medicaid rose by 5 percent. While the amount of income that an aged or disabled adult could have and still qualify for Medicaid rose by 26 percent.

Although poor children rely on the Medicaid program to a disproportionate degree, the cost of that reliance is relatively modest. Children cost the Medicaid program less than any other age group. Although they make up almost half the recipient population, only 19 percent of Medicaid expenditures goes for child health. The average per year expenditure for a child under Medicaid is $318, and the rate of growth of federal child health spending is much lower than for adults or the elderly. The services children and pregnant women purchase through Medicaid are the kinds of services that keep overall health care costs from escalating. Yet, they will bear the brunt of the Reagan Administration cuts.

Despite their heavy reliance on Medicaid and the relatively low cost of their care, children have suffered perhaps more than any other group of recipients as states, confronted with impossible choices in the wake of last year's federal Medicaid budget reductions and a deepening recession, continue to sharply curtail their Medicaid programs. By the end of Fiscal 1982, federal policymakers estimate that 661,000 children will have lost Medicaid coverage:

- Hawaii has eliminated Medicaid coverage of most poor children in two-parent families.
- Connecticut is considering eliminating from Medicaid all medically needy children in two-parent working families who have not sought welfare assistance but who do need help in providing health insurance protection for their children.
- Six states -- Washington, Oregon, Missouri, Kentucky, Iowa, and Utah -- have eliminated Medicaid for children living at home with parents who have lost or have no jobs.
- Virginia is proposing to stop Medicaid coverage completely for blind and disabled children under 18.

Some states are ending or severely limiting benefits:

- Virginia is considering dropping Medicaid coverage of hospital care for 12,000 poor children.
- Tennessee has eliminated all outpatient services -- clinic care, physician checkups, immunizations, prenatal care, etc. -- for medically needy families, families of four living on $200 per month. Other states, such as Washington and Vermont, are also considering limiting services for the medically needy.
- South Carolina is limiting the number of hospital days for which Medicaid will pay to 10 days per year. Limits of 20 days or fewer per year are also in effect in Kentucky, Louisiana, Alabama, Mississippi, and New Hampshire. Tennessee is proposing a hospital cap of 14 days per year. Arkansas, which has different ceilings on hospital stays for certain types of illness, reportedly allows only 6 days of coverage per year for certain pre-

> mature infants. In Maryland, where a 20-day limit per spell of illness was previously used, 30 percent of premature babies needed to be hospitalized but their families had no way to pay.
>
> The danger of dumping -- that is, refusing to admit poorly insured people for fear they won't be able to pay their medical bills -- is an increasing phenomenon.

In addition, families will lose Medicaid coverage because of changes made in the AFDC program. Federal funds for AFDC were cut by slightly over $1 billion. As a result, at least 660,000 families are expected to lose AFDC or experience reduced benefits. These families include one million children. Most of these families are "working poor families" employed in very low wage marginal jobs that do not provide health insurance coverage. In 20 states, loss of AFDC automatically means a loss of Medicaid:

> Ruby Smith (not her real name) has three children and lives in East Texas. From her part-time job she is able to earn about $250 per month. But because her earnings are greater than 150% of the standard of need in Texas for an AFDC family of four, she recently lost her $25 a month AFDC check and Medicaid card.
>
> One of Mrs. Smith's children, 10-year-old Jamie, has severe respiratory problems and needs medical treatment and medications at least once a month. He was hospitalized last year for his condition. Now that his mother has lost her Medicaid, no health care is available for Jamie in Cherokee County. Mrs. Smith's choices are to travel 180 miles to the University Hospital at Galveston; to travel 100 miles to Dallas and lie about her residency; or to give up her job and get her AFDC and Medicaid card back. She refuses to give up her job, at least for now. But if Jamie becomes seriously ill, she does not know what she will do.

Second: The Reagan Administration's implementation of the Medicaid provisions in the Omnibus Reconciliation Act are contrary to Congressional intent and have resulted in severe hardship for children and families:

As part of the Reconciliation Bill, states were given greater flexibility in the design of their Medicaid programs and now have the option of covering only certain groups of persons known as "medically needy." Medically needy persons include children in two-parent working families who are too poor to provide their children with health care but who do not qualify for cash assistance. (30 states have provided comprehensive medically needy programs. Approximately 1 million children have received Medicaid as medically needy beneficiaries). Congress stipulated, however, that any state with a medically needy program must provide all medically needy children under age 18 with out-of-hospital services and pregnant women with prenatal care and delivery. Regulations issued by the Reagan Administration deny children and pregnant women this care and limit the services they can get through Medicaid. As a result, some states are moving to cut children off Medicaid or limit the services they can get. Other states, which are developing limited medically needy programs, are not including those medically needy pregnant women and children who are entitled to health care under the Reconciliation Act. The result is unnecessary and severe hardship for children and their families:

> Kip and Robin Moon live in rural Tennessee with their 8-month-old baby girl, Leisha. Leisha was born two months premature last May, weighing two-and-a-half pounds. Doctors determined that the primary cause of Leisha's premature birth was that Robin, who had been extremely ill during pregnancy, did not receive adequate prenatal care. Because Robin was married to Kip, who was living at home with her, she was unable to qualify for Medicaid benefits during her pregnancy. The state of Tennessee, like all states, has the option of providing Medicaid for pregnant women whose husbands are at home, but has chosen not to do so. Had Robin received prenatal benefits under Medicaid, the cost of her pregnancy care would have been under $1,000.
>
> Leisha's premature birth and very low birth weight put her in critical medical condition. She was flown to Vanderbilt Hospital, where she stayed for several weeks. She was then brought back to Cookeville Hospital, where she remained two weeks more. The total cost of her care was approximately $25,000. Robin also required extensive hospitalization following the birth. The family had no way to pay for the care Robin and Leisha received.
>
> After Leisha was born, Kip attempted to get Medicaid for his wife and baby. He was told that, since he was at home and working, the family was ineligible for help. Shortly after this, both Kip and Robin lost their jobs. Over the past six months, both have searched for work, covering a 35-mile radius surrounding their home. Because of the severely depressed economy, neither can find employment. Kip earns about $30.00 a month slaughtering pigs. During Christmas week, he earned $5.00.
>
> Outside of Kip's slender earnings, the family has no income except food stamps. Leisha does receive WIC benefits because, at 8 months, she is still seriously underweight and anemic. The little health care the baby has received has been the result of some free assistance that a local

doctor has provided. He has now told the family that he cannot help them any more unless they are able to pay.

Third: The Reagan Administration's FY 1983 Budget in cutting an additional $2.1 billion from the federal Medicaid budget is demanding even greater sacrifices from those same children and families who have taken the brunt of the FY 1982 cuts.

Last year's budget decisions alone meant states lost $1 billion dollars in federal Medicaid funds in FY 1982. Another $880 million will be lost in FY 1983 because of further reductions in federal matching payments to states already enacted by Congress. In addition, the Administration is proposing to cut an additional $2.1 billion in FY 1983 by further shifting the cost of health care for the poor to the states and to Medicaid beneficiaries themselves.

Further Reductions in Federal Funds for Medicaid

The Reagan Administration is proposing to make two types of reductions in federal funding for Medicaid. First, the Administration proposes to reduce federal funding for "optional" services that states provide to all Medicaid recipients who receive welfare. Second, the Administration proposes to reduce federal funding for all Medicaid services provided to medically needy families. Medically needy families, although they do not qualify for welfare because they are working, are desperately poor nonetheless -- for example, a family of four in Tennessee is medically needy if its income is $205 per month.

Currently, Medicaid requires states to provide certain Medicaid services to families receiving welfare. Additionally, states may provide these families with certain "optional" services. They include such important services as institutions for retarded and mentally ill children; medical equipment such as braces, crutches, and wheelchairs for handicapped children; prescribed drugs; clinics furnishing primary and prenatal care to pregnant mothers and children who live in rural areas without doctors or in inner-cities where the only option is a hospital emergency room; and physical, speech, and hearing therapy. Reductions in federal payments will lead states to limit or drop these important services.

For poor mothers and children in need of these services, there is no distinction between "required" and "optional" services:

- For a pregnant mother, getting prenatal care from a neighborhood clinic is not "optional."
- For a diabetic child, getting an insulin prescription is not "optional."
- For a handicapped child who can walk only with the aid of braces, getting the braces is not "optional."

The Reagan Administration's proposal is no less than a calculated effort to force states to severely reduce or entirely eliminate a set of services. Even before the FY 1982 reductions, 31 states had already considered, actually reduced, or eliminated important "optional" services. As the FY 1982 budget reductions and the effect of the recession are felt throughout the country, these reductions are likely to increase in both numbers and severity. Further reductions in federal Medicaid funding for optional services will only hasten this trend.

To cut these services in a wholesale fashion is not cost-effective. Services vital to keeping mothers and children well and out of more costly health care settings will be cut by these reductions. For example, in New York State it costs approximately $4.00 per month to supply a pregnant woman suffering from high blood pressure with the prescribed drug she needs to control her condition. Without the medication, the possibility of severe damage to her baby rises dramatically, with a lifetime of hospitalization a substantial possibility. State officials estimate that the cost of such institutional care can run as high as $1 million over the lifetime of a child.

The severe reductions proposed by the Reagan Administration for optional services could force states to severely limit, or cut out altogether, their prescribed drug program, which could drive up the cost of states' Medicaid programs. A California Medicaid study conducted in 1972 found that as it became harder for families to get prescription drugs, inpatient hospital costs rose.

The Reagan proposal, by slashing federal funds for state medically needy programs, threatens to undo all of the improvement built into the medically needy program during 1981:

- Major reductions in federal funds for the medically needy programs, on top of large reductions made in Medicaid during 1981, will force states to eliminate categories of eligible persons, or pull out of the medically needy program entirely, instead of redesigning and better targeting their medically needy programs.

- The ripple effect of states' ending their support for medically needy families may ultimately be to force these families off their jobs and back onto welfare, which automatically entitles them to Medicaid. Thousands of families with serious medical needs are now able to stay off welfare and hold jobs. For these families, including over 1 million children, Medicaid is an essential support in their effort to be self-sustaining. If their Medicaid benefits are curtailed or eliminated, however, many families with sick children will have no choice but to reenter the welfare system in order to keep Medicaid.

- Medicaid medically needy funds are an essential revenue source for state public health and hospital systems, Community and Migrant Health Centers, and urban and rural clinics in underserved areas. If states are forced to pull out of the medically needy program, a significant source of revenue for public health systems for the poor will disappear, leaving these systems unable to function even for those who can pay their way.

Requirement To Share The Cost of Medicaid Care

The Administration's proposal to impose mandatory cost-sharing responsibilities on Medicaid beneficiaries for both outpatient and inpatient care will deny children access to health services, even though children have historically been underutilizers of essential health care:

- Data from a Rochester, New York study show that Medicaid children had 40% fewer preventive visits per year and 20% fewer illness-related visits than children covered by Blue Cross/Blue Shield.

- Children in poor families are 8 times as likely as children in high income families to have had no contact with a doctor and more than twice as likely not to have had contact for five years or more.

- It has been only since the advent of Medicaid that the serious health care utilization gap between poor children and their wealthier counterparts has begun to close. Overall, in 1976, [illegible]7% of children in the United States ages 1-5 saw a physician; the children ranged from 97% of those in families with high incomes to 78% of those in families with low incomes -- still a substantial gap in access to care. In 1963, before the enactment of Medicaid, the difference in utilization was much greater; only 52% of poor young children, as compared with 87% of those in the higher income group, saw a physician.

To understand how cost-sharing can stand between children and the basic care they need, take the case of a medically needy family of four, a pregnant woman living in Arkansas recently widowed who is about to deliver a child and has three children. The state of Arkansas permits a medically needy family of four approximately $260 per month to meet its survival needs -- food, shelter, clothing, and utilities. Currently, this mother can get health care for herself and her children free of charge. If the Administration's proposals are adopted and she is required to pay for her family's hospital and physician services, in the course of a month she might be forced to pay:

- $6.00 for a normal 3-day hospital stay following the delivery of her baby (if she needed a caesarean section her hospital costs would be approxamtely $14.00 for one week's stay);
- $6.00 for the baby's 3-day stay, again assuming no complications;
- $1.50 for the cost of her obstetrician's follow-up visit to her while in the hospital;
- $1.50 for her baby's newborn examination; and
- $3.00 for visits to the clinic for two of her other children, both suffering from winter colds and ear infections.

The total is $19.50 or almost 8 percent of her extremely limited monthly survival funds for herself and her four children. Thus, cost-sharing would probably deter this mother from getting all but the most extraordinary emergency care.

Studies clearly demonstrate that co-payments significantly reduce the use of necessary health care and substantially shift utilization patterns to far more costly institutional services:

- In 1972, then Governor Reagan instituted a Medicaid co-payment experiment in California. Studying the results of the experiments, first a team of public health professionals and then another independent team of researchers found that co-payments on physician and other outpatient services slowed the use of ambulatory care and significantly increased use of hospital services by AFDC families.

  Moreover, pharmacists participating in the experiment reported that beneficiaries who needed to take prescription drugs in certain combinations to control conditions such as hypertension, were "selectively purchasing" their medication, since they did not have sufficient funds to meet the cost-sharing requirements for each drug. Without the critical combination of drugs, recipients placed themselves in life-endangering situations and the threat of hospitalization dramatically increased.

  Thus, while co-payments were economical in the short run, the medical harm caused by reduced use was expensive, both in human and financial terms.

- In 1979, the Los Angeles County Board of Supervisors imposed co-payments on the County's public health clinics' services. Preliminary results of the co-payment rule showed that the monies received through co-payments amounted to only 80c for every $1.00 invested in billing patients. Furthermore, pediatric visits decreased 15% and immunizations were down 20-30%. One of the affected clinics reported that a "noticeable effect has been that women in the district have been seeking prenatal care later in pregnancy."

- In January 1980, the Bexar County Hospital District in San Antonio, Texas increased the cost of a clinic visit for out-of-county residents from 75c to $3.00. During February, the clinic experienced a 44% drop in patient visits. There can be no doubt that the increased fees resulted in people's staying away from the clinic.

  However, in addition to one death that was directly linked to the clinic's policy, Bexar County also experienced a sharp increase in emergency room visits at the hospital -- up 21% between January 1979, and June, 1980. Primary care provided in emergency rooms is episodic and 2-3 times more expensive than care provided in a clinic.

- The private health insurance industry is also deeply split on the issue of cost-sharing. A 1971 nationwide survey of all Blue Cross and Blue Shield plans found about half the plans found co-payments effective, half did not. Furthermore, of the half that found co-payments effective, almost half of those reported that only severe co-payments reduced utilization.

- While a study recently released by the Rand Corporation showed that co-payments significantly reduced use of health services by families, the study specifically noted that it did not measure whether access to necessary health care had been reduced. Indeed, the Rand study pointed out that cost-sharing had no effect on the single highest cost item in health care, namely the treatment intensity cost for hospitalization.

Finally, because the costs for prenatal and child health services are low, controllable and predictable, special measures to control children's use of primary health care are unnecessary:

- Costs are low in part because of less need for expensive hospitalization and the use of a wide range of health professionals.

- Costs are predictable because of the vast majority of expenses are for preventive care, a small portion for serious and unpredictable illness.

- Costs are controllable because of the "ceiling effect" on health expenditures for children when families have access to services. Costs rise moderarately when services are introduced but level off and remain constant over long periods of time.

In summary, CDF strongly opposes imposing co-payments on health care services for low-income mothers and children. While co-payments may decrease the use of basic health services in the short run, they will lead to a significant increase in long-term costs.

Any additional co-payment requirements under the Medicaid program must:

- Prohibit states from imposing any cost-sharing requirements on pediatric and prenatal and delivery services.
- Ensure that co-payments which are imposed are minimal by requiring states to use cumulative maximum limitations on the size of a family's cost-sharing obligations during any specified period of time. In this way, co-payments would be truly nominal in amount, not only for each item, but for the total amount each family is asked to pay.

Cutting Federal Funds for WIC and Block Granting WIC and The Maternal and Child Health Block Grant

As crucial as the issue of good health insurance coverage under Medicaid is for mothers and children, of equal importance is the availability of quality health services for families -- not only for those who receive Medicaid but also for families who have no insurance at all and therefore no means of paying for needed health care from private doctors, hospitals, or clinics.

Since the beginning of the New Deal, the federal government has maintained a strong commitment to ensuring that poor mothers and children living in severely medically underserved areas or without a means of purchasing health services nevertheless have access to decent health care. This commitment has been carried in part through the MCH Block, passed by Congress as part of the Omnibus Reconciliation Budget Act of 1981. It builds on the only federal health program targeted on mothers and children, the Title V Maternal and Child Health and Crippled Children's Program, passed by Congress 46 years ago. It replaces this program and six others which provide health services for mothers and children: Lead-Based Paint Poisoning Prevention Program; Sudden Infant Death Syndrome funds; the Supplemental Security Income Program of support services for disabled children; adolescent pregnancy services; Genetic Disease Program; and a program for the development of hemophilia diagnosis and treatment centers.

Almost 17 million pregnant women and children receive services ranging from prenatal care, checkups and immunizations to the most sophisticated types of medical care for crippling childhood diseases and intensive infant care for newborns.

This program supports a network of clinics in most counties across the country to which Medicaid-eligible families and poor families not eligible for Medicaid can go for routine health care for their children.

Last year's federal budget cuts took a heavy toll on this program. The Maternal and Child Health Block Grant was cut more than any other health services program -- 30 percent from Fiscal Year 1982 current policy levels. The impact of this cutback has meant clinic closures, cutbacks in services, in numbers of children who can get care, and in less staff to run effective programs:

- In Iowa, an administrator estimates that based on first quarter information, approximately 1800 Iowa children will not get medical care for such problems as congenital heart disease, hearing loss, cystic fibrosis, muscular dystrophy, cerebral palsy, and scoliosis because of the cutbacks in the MCH Block Grant.
- A public health official in Tennessee reports that the Crippled Children's Program is no longer admitting handicapped children to the program except on an emergency basis.
- In New Hampshire, as a condition for taking over the MCH Block, the legislature stipulated that "excess bureaucracy" must be cut. One "excess bureaucrat" who has been cut is the doctor who administers the Maternal and Child Health Block Grant.
- The New Mexico Health Department estimates that because of the cuts in the MCH Block Grant funds 2,000 fewer infants and children will get checkups, immunizations, and other preventive health services; 1,000 fewer women will get prenatal care and family planning services.
- The Human Resources Department in North Carolina has lost $2.8 million in funds for the MCH Block Grant program because of federal budget cuts. Over $1 million in budget cuts were made just prior to the assumption of the Block Grant. 44 staff positions have been cut. Approximately 500 fewer handicapped children will get the hospital care they need to correct or arrest handicapping conditions. Counties running health clinics will face up to a 13 percent reduction in funds.
- In Michigan, the federal cuts compound the problems for a state whose citizens are already straining under the burden of rising unemployment. In Detroit and Wayne County, three major health centers serving high-risk pregnant women and their newborns have been closed down affecting 600 women and almost 11,000 children. Local family planning projects are being reduced by 25 percent.

This reduction will result in no family planning services to 21,500 people and result in nearly 9,700 unintended pregnancies.

- In Arkansas, eleven health programs for children will be eliminated or reduced. The transportation system which brings babies from around the state in need of intensive care to Little Rock has been completely cut.

The Reagan Administration is proposing to further hamper states' effective use of limited MCH Block Grant dollars by proposing to add the additional responsibility of providing prescription food packages and nutrition services now provided through the Supplemental Food Program for Women, Infants, and Children (WIC) and cutting federal funds for these services by approximately $300 million. CDF opposes abolishing the WIC program by consolidating it with the MCH Block Grant and/or cutting federal funding.

If funding for nutritional services for low-income women and children now provided through WIC is cut by $300 million, 750,000 women, infants, and children will suffer the effects of nutritional deficiencies. Already, WIC is unable to reach all who need it. Tens of thousands of mothers and children are on waiting lists or turned away because there are insufficient funds to serve them. Not unrelated is the fact that in the U.S. today one out of every 81 infants and one out of every 47 non-white infants dies each year.

Pregnant and nursing women need to eat adequately and receive necessary medical care to have healthy babies. Infants and children need to eat adequately and receive necessary medical care to stay well. Less of either will reduce the chances children have to live and grow up healthy. Anything short of a full and focused commitment to both is detrimental to mothers and children. If WIC and MCH are merged, state health departments will lose money. WIC requires no state matching funds. The MCH block requires $3 in state matching funds for every $4 in federal funds. Any WIC matching requirements which call for new state expenditures will mean financially-strapped states will decline federal dollars and provide less food and health care for mothers and children. If the MCH state match is reduced or eliminated to accommodate the WIC merger, further cutbacks in an already minimal program will be assured.

To block grant WIC means to end one of the most effective federal programs on the books:

- A study at the Harvard School of Public Health found that participation in WIC is associated with a marked reduction in the incidence of low birth weight infants. (Low birth weight is one of the leading causes of death in the U.S. and is associated with higher rates of disability and retardation.) WIC infants averaged 128 more grams at birth than infants from a control group. The study determined, conservatively, that each $1 spent on the prenatal component of WIC averts $3 in hospitalization costs due to decreased need to hospitalize infants after birth.

- A study conducted by the Massachusetts Department of Public Health, in which births to 4,000 WIC mothers were matched with 4,000 comparable non-WIC births, concluded that the neonatal mortality rate for the WIC births was only one-third the rate for the non-WIC births.

- Data collected by numerous states and the Center for Disease Control show that WIC results in marked reductions in anemia.

Finally, Congress should be strengthening and improving health programs for children, not cutting them.

The health programs under the jurisdiction of the Senate Finance Committee have dramatically improved access by low-income mothers and children to essential health care. They have contributed to the notable improvement in health status among indigent children in this nation over the past 25 years.

Congress should look not to destroy these programs and turn back the clock on infant mortality in this country, but to broaden and strengthen their mandates. It is the duty of this Committee to keep alive and nurture the national commitment to good health care. The money is here to do it. For example:

- By doubling the current 8 cent tax on cigarettes, Congress could generate $1.8 billion in additional funds -- sufficient to nearly offset the Administration's proposed Fiscal 1983 cuts in Medicaid. According to the CBO, one likely effect of this is that 30 percent of teenagers who normally would start to smoke would not do so because they could not afford it.

- By curbing the more than $700 million cost overruns in the EF-111A aircraft, Congress could generate enough funds to not only restore funding for the MCH Block Grant, Family Planning, and Community Migrant Health Centers Programs to their Fiscal 1981 funding levels, but to actually provide each program, as well as WIC, with an increase.

CHILD WELFARE

Children who have been separated from their families because of the failure of basic family supports are also severely threatened by the Administration's FY 1983 Budget proposals. I would like to highlight several points today about the Administration's Child Welfare proposals.

First: Despite its rhetoric about protecting the truly needy, the Administration is bent on hurting homeless children.

There are over one half million children in this country who have been separated from their families and are living, often at great distances from their families, in foster family homes, group homes, and child care institutions. There are hundreds more children at risk of entering out-of-home care each day.

Over the last five years many members of Congress, including members of this Committee, have had an opportunity to hear first hand about the child welfare system's failures on behalf of these children. Adoptive parents, foster parents and other child advocates, state and local officials, and child welfare professionals all described the same problems: too many children enter foster care unnecessarily, linger indefinitely, often in inappropriate placements, and are denied permanent families either through return home or adoption. These same problems were identified in major national studies, like CDF's Children Without Homes, and in studies and exposes in individual states--California, Florida, Illinois, Ohio, New York, North Carolina, and Pennsylvania, to name only a few. Federal audits and

General Accounting Office reports also stated that children in care were often placed inappropriately and left to remain there for years, often at federal expense. The evidence was clear. An anti-family bias was evident at all points in the placement process. Throughout the country these children were victims of gross public neglect by state and local governments.

Congress realized that federal reforms and strong federal leadership were vital to protect these most vulnerable children. Support was overwhelming. H.R. 3434 passed the House of Representatives by a vote of 401 to 2, and received significant bipartisan support in the Senate.

As enacted, P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, gives the over one half million homeless children and the thousands entering care each month the hope of permanent families, their own or adoptive ones. It encourages the development of homemaker services and other services to keep children at home, and provides federal funds for adoption subsidies to assist with the adoption of children with mental, physical and emotional handicaps and other special needs. It also ensures the development of a range of procedural safeguards to protect children from entering care unnecessarily, to provide quality care for children who must be placed, and to ensure that children have case plans and periodic case reviews so that they are returned home or moved toward new permanent adoptive families in a timely fashion.

Despite the fact that this Act provides significant protections for needy children, who too frequently have no one to speak on their behalf, this Administration last year proposed eliminating the Act and including the Title IV-B Child Welfare Program and the Titles IV-A and IV-E Foster Care and Adoption Programs addressed by the Act in the Social Services Block Grant, leaving the future of these truly needy children to the same states that just a year earlier had been accused of severe neglect on their behalf. Congress last year recognized these half million children as truly needy and defeated the Administration's proposal to repeal the Act. P.L. 96-272 remained intact in the budget reconciliation process, and both foster care and adoption assistance were maintained as entitlement programs. Yet in its FY 1983 Budget the Administration has again proposed including the child welfare services, foster care and adoption assistance programs in a block grant, effectively repealing P.L. 96-272.

Second: The Reagan Administration's FY 1983 proposal for a Child Welfare Block Grant ignores the fact that P.L. 96-272 was designed to strengthen families and to ensure the most cost-effective use of public dollars.

The Adoption Assistance and Child Welfare Act of 1980 attempts to redirect federal fiscal incentives away from out-of-home care and to encourage states where possible to preserve families, or when placement becomes necessary, to move children quickly into permanent families through return home or adoption.

The reforms in P.L. 96-272 not only benefit children but are cost-effective. By discouraging the unnecessary placement of children in foster care settings that can cost as much as $60,000 per year, and encouraging the growth of alternatives that keep children in the home, P.L. 96-272 can lead over time to significant cost savings. Indeed the Department of Health and Human Services estimated, upon enactment of P.L. 96-272, that the law would save over $4 billion in out-of-home care costs over the next five years by reducing the average number of children in care by 30 percent.

There is evidence from a number of states and individual programs that the reforms anticipated by P.L. 96-272 will result in increased efficiency at the state and local levels and in long range cost savings. Savings will be realized when the costs of implementing services to prevent placements and reunify families and adoption subsidy programs are contrasted with the costs of leaving a child to grow up in foster care. Consider just a few examples.

> New York -- The Assistant Commissioner for Social Services for New York City testified before the Congress three years ago that services to prevent family break-up could be provided at a cost less than half of that required to keep a child in foster family care for only one year.
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> Washington -- In 1977 Washington State passed legislation mandating crisis intervention services for "families in severe conflict." About 40 percent of these services were delivered to the entire family in their own home. State officials estimate that the legislation and an increased emphasis on finding permanent homes for children saved the state about $2 million in a six-month period alone.
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> Iowa -- During a three year period ending in November 1978, the State of Iowa'a Department of Social Services ran, in a seven county district, a group of preventive services programs for children who had been determined to need institutional care. The services were delivered to families in their own homes, and resulted in an estimated savings of over $1 million.
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> California -- San Mateo County's efforts to implement reforms similar to those in P.L. 96-272 resulted in a 33 percent reduction in their foster care caseload during a three year period from 1977 to 1980. Such a decrease is particularly significant when

contrasted with the fact that during that same period protective services complaints increased 46 percent in the county.

Pennsylvania -- An "Agressive Adoption" program instituted in Cumberland County resulted in the total number of children in foster care being cut in half in a five-year period, with an estimated savings to the county of over $600,000 when contrasted with direct expenditures for maintaining those children in care.

Minnesota -- Minnesota currently has over 208 children in adoptive homes who are receiving adoption subsidies at an average cost to the state of $140 a month, a significant savings when contrasted with the average foster care costs for these same children which averaged $450 a month.

California -- One thousand and fifty-six children in Los Angeles County who had been in foster care were adopted during 1978-1980, and estimates of first year savings to taxpayers from the placement of these children was over $14 million.

Significant savings are evident too when you contrast the costs of the alternative services with the costs to the state when children who have been harmed by the foster care system end up spending their lifetime in institutional care. Experience in California has shown that half of the children who enter care at age 7 or 8 and grow up there can be expected to spend at least half of their adult lives in other institutions at a cost to the state for each of them of $25,000 - $30,000 per year. Data from a limited survey in New York City revealed that nearly half of the abused and neglected children studied later re-entered the system as delinquents or status offenders.

The evidence is clear that the reforms encouraged by P.L. 96-272 and implemented, at least in part, in a number of states are directed toward permanent families and are cost-effective as well. The Reagan Administration proclaims budgetary wisdom but in proposing the Child Welfare Block Grant ignores findings like those just described that public dollars used to keep families together or to move children into permanent adoptive families are more cost-effective in the long run than placing or leaving children in out-of-home care.

Third: The Reagan Administration's FY 1983 proposal for a Child Welfare Block Grant will effectively repeal P.L. 96-272 and deny needy children their entitlement to foster care and adoption assistance.

In its FY 1983 Budget proposal, the Administration has proposed, once again, to include the child welfare programs in a block grant. The Child Welfare Block Grant would include the Title IV-B Child Welfare Services and Training Programs, and the Titles IV-A and IV-E Foster Care and Adoption Assistance Programs addressed by P.L. 96-272. Funding for the block grant would be limited to $380 million for FY 1983 and thereafter. This limit would eliminate a needy child's entitlement to basic foster care and adoption assistance. Although the Administration asserts that the block grant would allow states additional flexibility to provide alternatives to foster care, in fact, $380 million is approximately the amount of federal funds estimated to be necessary for foster care in FY 1983. Further, the $380 million level is over 22 percent below the current funding levels for these programs and 46 percent below the funding levels originally anticipated in P.L. 96-272 for FY 1983, which are essential to move toward the family permanence homeless children need.

Passage of any child welfare block grant would effectively repeal P.L. 96-272. States would no longer be given fiscal incentives to develop protections for individual children in care, such as case plans and periodic case reviews, or to ensure that children receive quality care and permanent families. Incentives for the states to develop cost-effective programs to keep families together and to reunify families that are separated would be eliminated, as would incentives for the adoption of special needs children.

It is especially tragic that this proposal to eliminate efforts to significantly strengthen our nation's child welfare system comes at the same time that other cuts of at least $2 million in the State grant portion of the child abuse program, $1.2 billion in AFDC, $2.1 billion in Medicaid, $2.4 billion in Food Stamps,and $426 million in the Social Services Block Grant are being proposed. If these cuts are accepted by the Congress, basic family supports will be further undermined, forcing more and more families to turn to the child welfare system for help as a last resort. Yet if the reforms in P.L. 96-272 do not go into effect, an opportunity to turn around the damaging practices of a $2 billion foster care system in this country will be lost. It will be business as usual. Homeless children, the truly needy, will continue to be hurt.

SOCIAL SERVICES

At the same time the Administration is slashing away at the only federal program which protects children through basic income supports and is threatening the programs and protections offered children most at risk in the child welfare system, the Administration has proposed still deeper cuts in the Social Services Block Grant out of which states finance a range of supportive services programs for needy children and their families.

Although I am going to spend most of my time today talking about the impact of existing and proposed cuts on child care, I would like to first make a couple general comments about the Administration's attack on the social service programs. First, if the Administration's proposed FY 1983 cuts in the Social Services Block Grant are approved by the Congress, the program will be funded in FY 1983 at $1.9 billion. This is more than $1 billion, or 36 percent, below its FY 1981 funding level. Yet by cutting back on funding for crucial family support programs, the federal government is forcing states to bear the burden of significantly increased long term costs for some families. For example, the support services provided under the Title XX program, while never sufficient, have kept some families intact and prevented the need for more costly out-of-home care for their children. Title XX funds have also contributed to the development of community-based treatment programs for emotionally disturbed children and other children with special needs, thereby averting their need for more costly institutional care. The proposed $1 billion reduction in the Social Service Block Grant is part of the Administration's concerted attack on a range of cost-effective preventive service programs in the areas of health, social services and child welfare.

Second, as I will describe in more detail, the proposed reduction in the Social Services Block Grant is totally inconsistent with the Administration's professed desire to get more people working. Such a reduction in funding, particularly when coupled with the 22 percent reduction experienced for FY 1982, would undoubtedly have a severe impact on the availability and quality of child care for parents who are already working, in training, or waiting for work. Further, at the same time the Administration is talking about mandating workfare for all AFDC recipients, it is also eliminating the WIN program, the only source of counseling, training and job support services for AFDC recipients, and suggesting to states that these crucial job-related support services can be funded under the Social Services Block Grant.

With the above points as a context, I would now like to discuss in more detail the impact of what has occurred and what is proposed on child care.

CHILD CARE

There is no federally supported service more closely bound up with the ability of parents to work and support their families than child care. Our failure to respond to the need for child care puts the most vulnerable families in our society in the position of making an impossible choice: between leaving their children in inadequate, even harmful child care arrangements; and simply not working and depending on the public dollar for survival.

The supply of child care lags so far behind need that as many as 6 to 7 million children 13 years old and under, including many preschoolers, may go without adequate care while their parents work.

The so-called typical American family--two parents, a male wage earner and a mother who stays home to care for two normal children--describes only one out of every 21 American families today. The majority of America's children are growing up in families where all parents in the home work:

- o 42 percent of mothers with children under age three are in the labor force.
- o 54 percent of mothers with children between ages three and five are in the labor force.
- o By 1990, about half of all preschool children, or about 11.5 million, will have mothers in the labor force, as will about 17.2 million or 60 percent of school-age children.

For many children in one-parent working families, the need for child care is especially critical. Over one-third of these families, most often headed by women, live below the poverty level.

The need for infant care is steadily climbing. At the other end of the spectrum, the lack of after-school programs leaves millions of school-age children as young as six years old waiting up to four hours a day in empty homes or in school yards until parents return from work.

What Federal Programs Exist and Who Benefits?

A dismal picture emerges for low-income children when the expanding need for child care is juxtaposed against severe cut-backs in federally funded child care programs. Most affected by the budget ax are those children living in poor working families or whose parents are in school or training, trying to get the skills to break the cycle of welfare dependence. Major federal child care programs include:

- Title XX of the Social Security Act, which subsidized care in licensed centers and homes for approximately 750,000 low-and moderate-income children at a cost of $650 million in FY80. The Omnibus Budget Reconciliation Act of 1981 amended Title XX, reducing funding from $3.1 billion to $2.4 billion and eliminating a special $200 million earmark for child care that was 100 percent federally funded. It also eliminated the requirement that states supply $1 for every $3 in federal money.

- Head Start, primarily a part-day program, offers educational, nutritional, medical, and social services to 372,000 low-income children and their parents. It cost $820 million in FY81.

- The Child Care Food Program, enacted in 1975, reimburses child care centers, family day care homes, and after-school and Head Start programs for meals and snacks. It served over 725,000 low- and moderate-income children and cost approximately $351 million in FY81.

- The AFDC Child Care Disregard, which compensates AFDC families for their child care expenses up to $160 a month per child. In 1977, it served an estimated 145,000 children at a cost of $75-$100 million.

- The Child Care Tax Credit, originally enacted in 1976, provides a federal income tax credit for taxpayers who require child care for their dependent children in order to work or seek employment. The credit, which represents the single largest federal child care expenditure, is currently claimed by 3.8 million families, mostly middle- and upper-income. The tax credit cost the federal government approximately $1 billion in 1981. Until passage of the Economic Recovery Tax Act of 1981, the maximum credit was 20 percent of expenses up to $2,000 for one child or $4,000 for two or more children. The Tax Act provides a sliding scale beginning at 30 percent for those earning $10,000 or under a year, leveling out at 20 percent for incomes of $28,000 per year and up. The maximum amount of expenses against which the credit can be taken has been increased to $2,400 for one child and $4,800 for two or more children. Because the credit is not refundable, people whose incomes are too low to owe any income tax cannot benefit from these expanded credit provisions.

What Impact Will the FY 1982 Cuts Have?

An estimated 150,000 families will lose Title XX funded child care services. Parents trying to work and get off welfare will be undermined as children living in poor working families will be the first excluded from Title XX services.

Previously, eligibility for free Title XX services was restricted to families with incomes of less than 80 percent of the state's median income, with some partial subsidies for families up to 115 percent of the state's median income. Many states have responded to reduced federal social services dollars by lowering the income eligibility criteria for child care:

- Pennsylvania has changed eligibility criteria so that families with incomes over 90 percent of the state median income cannot enroll their children in state-supported child care programs even if they agree to pay the full fee.
- In Washington state, working families earning above 38 percent of the state median income ($773 a month for a family of four) are no longer eligible for subsidized child care.
- Rochester and Syracuse, New York, will no longer provide child care subsidies to new income-eligible families. In Albany, parents earning $8,000 a year must pay $16 a week (or $800 a year) for child care. One Albany single mother who is losing the child care subsidies

for her two children asked: "Why are they doing it to day care centers, I don't understand. They've helped a lot of single working parents."

- One-third of the 300 families who received Title XX reimbursement in centers connected to Central Child Care of West Virginia are no longer eligible because of stiffened eligibility guidelines. To remain eligible for subsidized child care, many desperate parents have asked for reductions in already minimal salaries.

Many working mothers will have to uproot their children and search for cheaper, less desirable care. Many states will make less money available to monitor or maintain minimal child care standards. Many are already reducing their standards that child care programs must meet. As a result, children will suffer as parents shift them from stable and familiar arrangements to less adequate and sometimes even harmful arrangements:

- One New York mother has arranged to have her child's grandmother, who works a night shift, care for the child during the day.

- Reports come from child care providers in Des Moines, Buffalo, and other cities of increasing numbers of latchkey children without after school care.

Because of decreased funding many child care providers may find it impossible to maintain their programs unless they can attract and charge higher fees to middle-income families. When hard-pressed middle-income families find the increased costs too burdensome, more centers may be forced out of business because of the decreased demand for services. Among the cutbacks that will increase pressure on child care providers and parents, in addition to those already described, are those in the following programs:

Child Care Food Program. Reductions of 30 percent in the Child Care Food Program will lead to increased child care fees for poor parents, to a decrease in the number of children covered by child care services, or both.

AFDC. Child care deductions for working mothers on welfare have been limited to $160 per child per month. AFDC workfare programs may divert child care resources away from AFDC and other low-income mothers already working who need publicly supported child care to continue working. If states try to spread their resources thinner to meet the additional demand for child care that work programs create, it could result in child care of dubious quality, given by untrained, poorly paid providers. For example:

o In Massachusetts, the Department of Social Services has eliminated one-third of its preschool child care slots and replaced them with slots for school-age children. Priority for these new school-age slots will go to mothers on welfare who are enrolled in a WIN work demonstration project (another work program under AFDC)and to mothers who have lost their welfare benefits entirely. The state has given the lowest priority to children of AFDC recipients who work, go to school, or are looking for work. Meanwhile, the Welfare Department, which runs the WIN demonstration project, has issued a letter stating that replacements for the preschool slots should be 55-cents-an-hour babysitters paid for by the Department of Social Services. This low rate will make it extremely difficult to find adequate quality child care.

CETA. Elimination of the Public Service Employment component of CETA has caused thousands of child care programs to lose child care workers, secretaries, and bookkeepers, which they are hard pressed to replace.

Child Care Tax Credit. While Congress cut direct child care subsidies for lower income families, it simultaneously helped middle- and upper-income families by increasing the benefits available through the Child Care Tax Credit by raising the maximum amount of expenses against which the credit can be taken. In an attempt to provide additional benefits to working families, Congress created a sliding scale. Although we support the increased credit, we were disappointed that it was not made refundable so that parents whose incomes are too low to owe any income tax could benefit from the new expanded credit provisions.

Many low- and moderate-income working families ironically may realize little benefit from the new tax credit provisions. Those who lose Title XX funded child care will not be able to make up the difference through the tax credit, which at 30 percent provides a maximum benefit of only $720 a year for one child and $1,440 for two or more children. In contrast, the cost of full-time preschool child care at $1 an hour is at least $2,000 a year.

These same families face reduction or the complete loss of child care food and school lunch subsidies. It is unlikely that the sliding scale will allow working families to purchase improved child care for their children. In fact, other cuts may limit their disposable income so that they may be forced to turn to cheaper child care options. Consider the benefits of the Child Care Tax Credit to lower-income working families juxtaposed against increases in school meal costs (assuming that increased charges for the child care food benefits will be reflected in higher fees to parents):

- A two-parent family with two children has a total income of $15,100 per year. The father earns $4.70 per hour, the mother $3.35. One child is in elementary school, the other is in a half-day kindergarten. This family pays $20 a week for day care for the younger child during the school year, and $40 per child a week during the summer, for a total of $1,840. Their total benefits from the Child Care Tax Credit will be $478.40, $110.40 more than under the old 20 percent credit. This family has lost eligibility for reduced-price lunches in school and in the day care center. They now pay 85 cents per lunch per child, compared to 20 cents last year. Their additional costs for lunches for their children are $334 for a year. Their net additional costs come to $223.60 for the year.

- A single mother with three children has a total income of $11,200 per year ($5.60 per hour). Two of the children are in elementary school, one is a preschooler in full-day day care. This family has lost its eligibility for free lunches for the children; the mother now has to pay 40 cents per child per lunch, or $300 more per year. She pays $40 per week for day care for the youngest child, and the same amount for each of the older children during the summer, for a total of $3,120 per year. Her Child Care Tax Credit is $905.80, $281.80 more than under the old (20 percent) credit. Her net additional cost is $18.20 because of the increase in lunch prices.

The Children's Defense Fund urges you to amend the child care tax credit to allow for refundability and to expand the sliding scale to begin at 50 percent for incomes $10,000 and under. Unless this occurs, poor working families will continue to find no pea under the Reagan Administration child care shell game.

Even with refundability, however, child care expenses represent an out-of-pocket expense for families with little flexibility regarding their cash flow. A targeted amount of money to directly subsidize child care for these families is also needed.

This could be accomplished by adding a mandated child care earmark to the Title XX Social Services Block Grant. Such a provision would not involve drafting child care legislation but would guarantee that dollars are protected for direct services in child care.

The Proposed FY 1983 Budget Cuts

The child care dilemma created for poor and working families by the FY 1982 budget cuts and legislative changes will grow even more serious if the Administration's budget proposals for FY 1983 become a reality. An 18 percent cut in the Title XX Social Services Block Grant (from $2.4 billion to $1.974 billion) will mean that about 100,000 additional families will lose child care services. The Child Nutrition Block Grant, merging the Child Care Food Program with School Breakfast and reducing funds by over one-third, will mean even less support for quality child care programs. Competition will be keen at the state level for diminished funds. School food service providers represent a far stronger constituency than the child care community. The result will be that some child care providers will be forced out of business because of this further round of cuts and those that remain may offer lower quality services. An additional $1.2 billion cut in AFDC will diminish more low-income families' access to child care. Finally, proposals to eliminate the Appalachian Regional Commission and the Work Incentive Program will further limit child care opportunities for working lower-income families.

Conclusion

Mr. Chairman and Members of the Committee: In 2010--28 years from now when many of us in our late thirties, forties, and fifties, will be moving toward or be of retirement age--there will be more elderly people per worker and fewer children as we become an increasingly aging society. Each worker will become more important as fewer become available to support more older dependents. That potential 2010 worker was recently born or is about to be born.

- 1 in 5 of them was born poor and 1 in 4 will depend on the AFDC program we are cutting to the bone at some point in his or her lifetime.
- 1 in 2 will grow up in a family where all parents work and often face inadequate, even harmful child care arrangements. We are cutting child care.
- 1 in 3 has never seen a dentist, and 1 in 7 lacks access to preventive health care. Their numbers will grow, along with costly remediative medical costs, as a result of short-sighted cutbacks in Medicaid, maternal and child health, and community health centers.
- 1 in 4 will drop out of school before they graduate and will not be able to read and write and compute well enough to read the want ads or fill out the applications for the rapidly shrinking number of unskilled jobs. Millions more are going through an education system that has not prepared itself to respond to the new demands of an information economy and increasingly competitive world.
- 1 in 2 will grow up in single-parent families, one-third of whom will be poor. But these are the families President Reagan is beating into the ground through severe across-the-board cuts in Medicaid, AFDC, food stamps, energy and housing assistance, child care, and jobs.
- Almost 600,000 a year are being born to teenaged mothers, many of whom have gone without prenatal care which greatly increases the likelihood of producing babies of low birth weight or with birth defects. Yet we are slashing the family planning funds needed to avoid more pregnancies, and the support services to help them remedy their mistake and avoid lifelong dependency.

- o 500,000 are going unnecessarily homeless, in costly foster and institutional care, denied the nurturance and family stability that every child deserves. And President Reagan would cut new protections and funds to help them grow up in a family.

These policies will cost billions in future remediation (medical costs, foster and institutional care, court costs, jails); in services (welfare dependency, social services); and in lost productivity (joblessness, untrained minds and unhealthy bodies). And they will cost us more than we can measure as we stray from our historical path of becoming a decent and disciplined society.

Those of us who care about children must help Americans of all persuasions to examine more deeply our feelings and beliefs about what is right and just as well as cost effective.

The Children's Defense Fund has just completed a national conference of more than 500 child advocates from all over the country. We came together to learn about the Reagan budget and to map strategies for educating the public and the Congress to the needs of the whole child and to the need to act now to protect the futures not only of today's children, but of the children born tomorrow and next year and in the next decade.

At this conference were church leaders, parents, doctors, foundation officials, social workers, Head Start directors, academics, and public and private agencies. Despite the variety of backgrounds, professions and disciplines, we all shared one thing--a commitment to turning back the dangerous trends initiated in the Fiscal 1982 budget and to replacing them with affirmative policies that will support and strengthen our children in the coming decades.

We need your help; we want to work with you and to keep in mind as we face the difficult choices ahead at all times the words of Dwight D. Eisenhower, who said in 1953:

> "Every gun that is made, every warship launched, every rocket fired signifies..a theft from those who hunger and are not fed, those who are cold and are not clothed."
>
> "This world in arms is not spending money alone."
>
> "It is spending the sweat of its laborers, the genius of its scientists, the hopes of its children."

The **Chairman**. Senator Wallop?

Senator **Wallop**. No questions.

The **Chairman**. Senator Byrd?

Senator **Byrd**. No.

The **Chairman**. I appreciate your statement. It is not unexpected, I might say. However, I don't want to exempt anything from budget scrutiny including social programs. I think there are areas in the social programs that we ought to look at carefully.

We had Secretary Schweiker sitting there last week describing a budget of $284 billion, an increase of 8 percent over last year; 95 percent of his budget is in what we call entitlement programs. It is pretty hard to say we can't touch anything in that $284 billion budget.

I share the views you have expressed that we can't cut only programs that impact on low-income people or children or the handicapped, but I am not yet convinced that those programs are without fault in some area that we ought to address. If we don't do it, I'm not certain what the future may be.

I appreciate your taking the time to remind us that there are some concerns that might be overlooked, but I find this committee fairly sensitive to the needs you have addressed, whether it is welfare, AFDC, title XX, or whatever. We hope when this year ends that we will have made some headway.

The other side of the coin is, if we don't lower the deficits and lower interest rates, there might not be much of a future for any of these programs. People can't pay taxes when they are out of work.

Ms. **Deering**. Mr. Chairman, may I just add something?

You and your committee might be interested to know that the Association and the Children's Defense Fund are developing a project called Child Watch, which we will be initiating across the country, to monitor the effects of the Federal budget cuts on children's programs in four areas. This has just begun, and we will be looking forward to sharing this information not only with our individual communities but with your committee as the year progresses. And I think the information we glean from this project will really provide valuable assessment in the communities.

The **Chairman**. I wonder if they monitor areas we might cut spending, too. I can already tell you what you are going to find in that study, that the cuts are terrible, that they have a severe impact, and that we shouldn't have done it. You don't have to have the study; we know what the findings will be. Why aren't you out there trying to tell us that this is a good program? Other programs in your area, not just everything outside your jurisdiction, should be addressed. That would be more helpful than some study where we know what the conclusions would be.

Senator **Wallop**. Mr. Chairman, if I could, I would add to what she said.

A study like that, instead of being a study in finding faults, as you suggested, is trying to find some benefits, and as well might be able to find some alternative means of traveling down the same road and achieving the same goals.

Ms. **Deering**. Right. The purpose of the project is not just to find the faults; it is to find out just what is going on, how the cuts in the children's programs are being implemented—maybe they are going to work. So that is not the purpose.

The CHAIRMAN. Maybe it was a bad program to start with. I think Senator Wallop has indicated there might be another way to do it. We get many vested interests here who don't want to change anything.

Ms. DEERING. We are not trying to draw any conclusions prior to the project.

Senator WALLOP. I just might point out that anybody in our world, regardless what side they come from on a given issue, is always a little skeptical about those. I just might say this morning that 2½ hours before the President spoke in Oklahoma UPI was out telling the world how the public had reacted.

The CHAIRMAN. Do you mean ahead of the speech?

Senator WALLOP. Two and a half hours before he gave it they were reciting the reaction of the public. I don't mean to equate what Child Watch is going to do to that, but it wouldn't be the first time that such a thing had happened—that the conclusions of a study were contrived before the study began.

Ms. DEERING. Well, let me assure you, that's not the purpose we have.

Senator WALLOP. I think that's what the chairman was saying, that the purpose would be really very much better served if you would find out what was good and what was bad and that there were alternative roads that were more effective to achieve the same end.

Ms. BLACK. Well, I think people are trying to find alternative methods; and certainly in child day care, which I am very involved in, we are finding alternative methods to serving the same group of people as well as broadening the base—now, this is in New York City.

I think a crucial issue here, though, at the local level is this fight for the dollar. Because our tax levy dollars which are being put into the cutbacks in human services—in other words, the Feds to the locality—now we are having to compete not just within the turf of human services but we are having to compete with the uniformed services plus education. And this is a real realistic point that I think has to be considered by the Congress in its cutbacks.

Senator BYRD. May I ask this question? The term "budget cuts" has been used in the programs that the three of you are interested in. Has there actually been a reduction in the budget, or has there been a reduction in the rate of increase in the budget?

Ms. BLACK. My testimony has some charts in it, Senator, which show what the cuts have been in both title XX, AFDC, as well as Public Law 96-272 and what the effects are, and then what the proposed cuts are and what those effects will be.

In title XX alone, if the additional proposed cut goes through, we will have a $1.225 billion cut since August 1981.

So we are feeling cuts and we are trying to make alternative kinds of plans.

Senator BYRD. Cuts below what you are receiving now?

Ms. BLACK. That is correct.

Senator BYRD. In that particular program?

Ms. BLACK. Yes.

Senator **Byrd**. Thank you.

The **Chairman**. Again, I don't quarrel with those who defend those programs. You must do that, or somebody would be happy to take them away. On the other hand, we have had witnesses all last week and we are going to have some more this week who don't want us to make any revenue changes in the tax laws, either, because nobody likes to pay taxes. We haven't had a single volunteer suggest they would like to pay more taxes, and no volunteer that wants any reduction in their program.

I guess the point is, if we accepted everyone's testimony, the budget deficit would remain $150 or $160 billion. And you are competing; there is no doubt about it. There are only so many dollars, and we have to raise the debt ceiling. That's going to be in this committee in about a month. It is $1,078.9 billion now that many of these children you talk about are going to be saddled with unless we do something.

Ms. **Hoffman**. Senator, in CDF's budget analysis we have about $30 billion in alternative cuts in revenue sources which we propose.

The **Chairman**. Oh, in defense?

Ms. **Hoffman**. No; in a combination of things, including some tax proposals. It's an appendix to our book. And we also intend to be developing some clear alternative proposals transferring funds to children and family support programs from some of these sources to bring before Congress.

The **Chairman**. Hopefully it is something in our jurisdiction. Defense would come in and say "cut entitlements," and you come in and say "cut defense." That doesn't help us much at all, unless you and Cap Weinberger get together to see if we could work it out.

Ms. **Black**. We are going to have to increase local taxes if we do not continue to have more revenue from the Federal side.

The **Chairman**. We will either have to increase local taxes or increase Federal taxes. Which would you prefer?

Ms. **Black**. Maybe I am one of the few witnesses that would say that we shouldn't have cut the taxes. Maybe I come from a different viewpoint. But I do know that if we maintain the cuts in tax revenues we are going to get taxes raised both at the city and the State level in New York, and maybe it will be higher than if you hadn't cut the Federal taxes. I don't know.

The **Chairman**. Well, I don't want to get into an argument on that, but I think there are some areas—and I don't single out New York or my own State—that could do a little more in some of these programs. The Federal Government doesn't have all the answers or all the money or all the wisdom. I think the people in New York or in Topeka, Kans., are just as sensitive as those in Washington, D.C. But that's another whole new program called New Federalism.

Thank you very much.

Ms. **Black**. Thank you.

The **Chairman**. Now we will go back to our regular order: Mr. James Spang, executive director, Polinsky Memorial Rehabilitation Center, Duluth, Minn., on behalf of the American Occupational Therapy Association; and Mr. Francis J. Mallon, American Physical Therapy Association, executive director.

Again I would indicate, as I have before, briefly summarize your statements so that the other four witnesses who remain after you have finished will have some time before this hearing adjourns at 11.

STATEMENT OF A. JAMES SPANG, EXECUTIVE DIRECTOR, POLINSKY MEMORIAL REHABILITATION CENTER, DULUTH, MINN., ON BEHALF OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, ROCKVILLE, MD.

Mr. SPANG. Thank you very much, Mr. Chairman.

My name is A. James Spang, and I am the executive director of the Nat Polinsky Memorial Rehabilitation Center in Duluth, Minn. Hopefully, we can help the Federal Government reduce its expenditures.

I am appearing today on behalf of 10 national organizations. In addition to those stated on the witness list, my testimony is endorsed by the American Congress of Medical Rehabilitation, the American Academy of Physical Medicine, the Association of Academic Psychiatrists the National Association of Medical Directors of Respiratory Care, and the nine disability groups that will also be testifying later this morning.

My center is a member of the National Association of Rehabilitation Facilities.

Polinsky is a free-standing comprehensive outpatient rehabilitation center which provides medical and vocational services to adults and children in northern Minnesota, northern Wisconsin, and upper Michigan. It also provides services to inpatients in Miller-Owann and St. Mary's Hospitals locally.

My statement today addresses the administration's proposal to repeal section 933 of the Omnibus Budget Reconciliation Act of 1980. That act provided provider status for a comprehensive outpatient rehabilitation facility such as ours.

Mr. Chairman, my complete statement has been submitted for the record, and I would like to summarize it at this time.

First, the organizations that I represent feel that section 933 is desirable and cost-effective. Repeal of that section would not, in our judgment, save money. Congress rejected a repeal last year, and the administration has not supported its request for a repeal with any justification again this year.

Section 933 was enacted to rectify a gross inequity in the medicare program, both for facilities and for beneficiaries. It was enacted to provide for comprehensive outpatient services in a less-costly setting.

Since 1965 medicare has covered comprehensive outpatient services, but only when supplied by a hospital. Section 933 of the Omnibus Reconciliation Act of 1980 did not add a benefit to medicare; instead it only made it available in a different setting, the comprehensive outpatient setting.

Outpatient facilities provide these services at a lower cost. In my own area, for example, the outpatient facility charge for occupational therapy is $46. The local hospital's average charge is $54. As another example, a respiratory therapy program in Loma Linda, Calif., has shown a savings of $400,000 for 80 patients in their outpatient program, and they have shown a significant reduction in hospital days when patients were treated through that comprehensive outpatient program.

Section 933 was effective for a facility's accounting period beginning on or after July 1, 1981. Despite repeated meetings and urgings by these organizations and by several Members of Congress, regulations implementing this provision have never been published.

On February 19 four of the organizations, three local facilities, and three medicare beneficiaries sued Secretary Schweiker to compel implementation of the law.

Mr. Chairman, we feel that section 933 makes rehabilitation more readily available at a lower cost. I firmly believe that repeal of the provision would not be in the best interests of the medicare program and would discriminate against comprehensive outpatient rehabilitation facilities and beneficiaries. In addition, it will require those comprehensive outpatient facilities who deliver services to incur a great loss. It will promote inpatient care and the use of hospitals for outpatient services, generally at higher costs, and it will require beneficiaries to bypass facilities close to their homes.

I urge the committee to reject the administration's proposal and to seek information as to why the regulations have not been issued.

I would also like to thank you for the opportunity to appear here today and would be happy to answer any questions that you may have.

[The prepared statement follows:]

Statement of A. James Spang
Executive Director
Polinsky Memorial Rehabilitation Center
Duluth, Minnesota

Committee on Finance
U.S. Senate

March 16, 1982

Mr. Chairman, my name is A. James Spang. I am the Executive Director of the Polinsky Memorial Rehabilitation Center. I am appearing today on behalf of a coalition of health care groups including the National Association of Rehabilitation Facilities, the National Easter Seal Society, the American Occupational Therapy Association, the American Physical Therapy Association, the American Association for Respiratory Therapy and the American Speech-Language-Hearing Association. This statement is also endorsed by the American Congress of Medical Rehabilitation, the American Academy of Physical Medicine and Rehabilitation, the Association of Academic Physiatrists, and the National Association of Medical Directors of Respiratory Care.

The Polinsky Memorial Rehabilitation Center is a member of NARF. The Center is a free-standing outpatient rehabilitation center and provides a comprehensive rehabilitation program including both medical and vocational services. Our testimony today is addressed to the Administration's proposal to repeal the provision in the Omnibus Budget Reconciliation Act of 1980, P.L. 96-499, establishing provider status for comprehensive outpatient rehabilitation facilities and covering comprehensive outpatient rehabilitation services which they render under Part B of the Medicare Act. This provision, which was enacted as Section 933 of the 1980 Reconciliation Act is desirable, useful and cost-effective. Repeal would be a step backward for the Medicare program and it would not, in our judgement, save money. Last year Congress rejected a proposal to repeal this provision.

The Administration's FY 1983 Budget again proposes to repeal this provision of the Medicare act but (as was the case last year) with no analysis or justification. The Budget justification prepared by the Department of Health and Human Services (DHHS) does not address this item at all except to include it in its briefing memorandums as "other savings" for Medicare and to dismiss it along with another provision included in the Reconciliation Act, as low-priority benefit expansions. The Congress enacted this legislation to eliminate a gross inequity in the Medicare program, both for comprehensive rehabilitation facilities and beneficiaries, and to provide for the receipt of comprehensive outpatient services in a less costly setting than is now the case. It should not retreat from this action, particularly when there is no reason asserted for doing so.

Prior to this amendment, Medicare covered comprehensive outpatient services when rendered by a hospital. This was the law since the inception of the Medicare program in 1965. Outpatient rehabilitation coverage is not a new benefit; it is as old as the Medicare program. The change made by the Congress in the enactment of Section 933 does not add a benefit to the program, but rather makes it possible for Medicare beneficiaries to recieve the same covered services in a different setting. Section 933 became effective on July 1, 1981. Medicare patients were to receive comprehensive rehabilitation services from outpatient centers - many associated with NARF and Easter Seals - and these would be covered under Part B.

Since this provision has not been implemented, Medicare patients receive these services only in hospitals, generally at higher costs. The effect is to discriminate against fully accredited comprehensive outpatient rehabiliation facilities, often more accessible to patients and certainly equally competent. More importantly is the discrimination among beneficiaries in terms of their access to hospital and outpatient centers. The Budget estimates that repeal of this provision and Section 935 dealing with outpatient physical therapy will "save" a negligible sum in the current fiscal year and $19 million in FY 1983. This estimate assumes that the services are not covered by Medicare and ignores the fact that patients can go to a hospital for exactly the same services. The "savings" are therefore illusory. In fact Medicare costs will be higher if this provision is repealed.

Let me cite specific examples. The charge for one hour of occupational therapy at my Center is $46.00. We surveyed three hospitals in Duluth to obtain their charges for their outpatient service. The average of the three was $54.00. As another example, Mr. Chiarman, we are attaching two charts showing cost savings through a comprehensive pulmonary rehabilitation program currently operating in Loma Linda, California. The figures show a reduction in hospital days for patients suffering from specific pulmonary diseases when treated through a comprehensive outpatient rehabilitation program. This one program saved approximately $400,000 for the eighty (80) patients enrolled in the program. If Section 933 is repealed, Medicare will still cover the service, but at the higher cost. Moreover, there is a tendency for patients to remain in hospitals as inpatients if Medicare does not provide for outpatient coverage through facilities accessible to them. This is certainly the case for the older people covered by Medicare who typically suffer from stroke, arthritis, and similar debilitating conditions.

Mr. Chairman, these facts were recognized by the Congress two years ago when it passed the law (P.L. 96-499). Now it is proposed that this sensible action be reversed, not because of some analysis of rehabilitation and its costs and benefits, but rather because it is a small provision which is vulnerable to offhand dismissal. Repeal of this provision will not save any money. It will, I believe, cost the Medicare Trust Fund money by promoting inpatient care and the use of hospitals for outpatient service.

Again, I wish to emphasize that making outpatient rehabilitation facilities providers under Medicare was not an expansion of benefits. It deals with services that may be received and compensated under the Medicare program, but address only the site at which those services may be rendered. It is important that the Committee recognize that the elderly Medicare patients have a high incidence of arthritis and the effect of strokes. Rehabilitation services help to restore and maintain such patients to higher levels of function with accompanying self-respect and reduced dependence on their families and others. It is important to the success of the therapy accorded to such patients that it be provided without undue difficulty. Making such patients bypass outpatient rehabilitation facilities close to their homes to receive services at a hospital in order to qualify for Medicare does not make much sense for the patient or Medicare. I hope it also doesn't make much sense to this Committee.

P.L. 96-499 was signed into law on December 5, 1980. As of July 1, 1981, the Department of Health and Human Services had not published final regulations implementing the program nor even a Notice of Proposed Rulemaking. From December 1980 to July 1981 each of the represented organizations met with representatives of DHHS to discuss issues pertaining to the regulations, and to urge their prompt publication. A copy of one letter is attached.

Several members of Congress have requested from the Department of Health and Human Services an explanation of why the regulations had not been published and when they would be. The Secretary and officials at the Health Care Financing Administration answered them that these rules would be published by January 1982. This assurance is less than comforting since it is now March 16, 1982.

This entire time, facilities have not been paid by Medicare for services delivered. Beneficiaries were and are not receiving services.

This continued inaction prompted NARF, National Easter Seal Society, the American Association for Respiratory Therapy, American Occupational Therapy Association, three outpatient rehabilitation facilities and three Medicare beneficiaries to sue Secretary Schweicker on February 19, 1982 (NARF et. al. v. Schweicker, U.S. District Court for the District of Columbia, CA. No. 82-0494).

Mr. Chairman, I appreciate the opportunity to appear today for myself and on behalf of the organizations I am representing. I urge the Committee to reject the Administration's proposal to repeal this provision. I also urge this Committee to ask the Department why the regulations implementing the provision have not been published. This provision is insignificant in relation to the enormous questions of revenue policies and spending pending before this Committee. To Medicare patients in need of these services and the facilities which serve them it is of great consequence. Thank you.

ATTACHMENT 1

NARF
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

June 2, 1981

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Avenue, S. W.
309G Hubert Humphrey Building
Washington, D. C. 20201

Dear Dr. Davis:

I am writing to call your attention to the need for prompt action by HCFA to implement Section 933 of the Medicare and Medicaid Amendments of 1980. This legislation amended the Medicare Act to make comprehensive outpatient rehabilitation facilities providers under the Medicare program and to provide for coverage of outpatient rehabilitation facilities services which they render under Part B.

The provisions of this section are effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning after June 30, 1981. A great many facilities operate on a fiscal year which begins July 1. Accordingly many outpatient rehabilitation facilities which will be providers under this addition to the Medicare Act contemplate provision of services to Medicare beneficiaries and reimbursement therefor on the first of next month.

Many such facilities are members of the National Association of Rehabilitation Facilities and we have been in regular communication with various elements of HCFA regarding the development of regulations to implement the law. While this amendment to the Medicare Act has been on the books for over six months HCFA has not issued or proposed regulations nor, we are informed, has the drafting of such regulations been completed. It seems clear that immediate steps are required by your office to see that the law is implemented on the schedule prescribed by the Congress. This will necessitate the issuance of regulations which are effective immediately or some interim provision for delivery and reimbursement of services pending the promulgation of final regulations.

As I am sure you are aware, the Administration's budget proposed repeal of this provision as well as other amendments to the Medicare Act contained in the Omnibus Reconciliation Act of 1980. That recommendation has not been accepted by the Congress. Neither the Senate Finance Committee or the House Ways and Means Committee has included repeal of Section 933 in their respective reconciliation actions and there is no indication in either house that any other Medicare amendments are contemplated this year. To the extent that the delay in completing regulations to implement Section 933 has been related to an assumption of its repeal, this should no longer be the case.

A number of other national organizations share our interest in this matter including the National Easter Seal Society, American Association for Respiratory Therapy, American Occupational Therapy Association, American Physical Therapy Association and American Speech-Language-Hearing Association. I and representatives of these other organizations would welcome an opportunity to meet with you at your earliest convenience to review the status of this matter and to determine what actions are required to insure timely implementation of the law.

Sincerely,

James A. Cox, Jr.
Executive Director

ATTACHMENT 2

NARF
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

September 22, 1981

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Avenue, S. W.
309G Hubert Humphrey Building
Washington, D.C. 20201

Dear Dr. Davis:

On June 2, 1981 I wrote to you regarding implementation of Section 933 of the Omnibus Reconciliation Act of 1980. Your response of July 22 generally outlines the process for development of regulations, but does not establish any timetable for implementation of the coverage of comprehensive outpatient rehabilitation services mandated by Section 933. Further, your letter does not address the fact that the law became effective July 1, 1981 and that HCFA's delay in implementing it flaunts the clear intent of Congress as to when this provision is to be effective.

We are advised by the Office of Standards and Certification of HCFA that regulations have been drafted, but will not be published for some time because of internal review requirements. Publication, when it occurs will be for comment only. Under the most optimistic scenerio final regulations will not be published before April or May of 1982. Were this to be the case coverage provided by law would be delayed almost a year by administrative fiat. I submit that this is an intolerable situation.

This is to request your personal intervention to obtain prompt issuance of the regulations to be effective upon publication while being subject to comment and to revision as necessary. This approach could implement the law within the next 30 days.

Sincerely,

James A. Cox Jr.

James A. Cox, Jr.
Executive Director

ATTACHMENT 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201

NOV 19 1981

Mr. James A. Cox, Jr.
Executive Director
National Association of Rehabilitation Facilities
5530 Wisconsin Avenue
Suite 955
Washington, D.C. 20015

Dear Mr. Cox:

This is in reply to your letter to Dr. Carolyne K. Davis dated September 22 concerning our plans to implement Section 933 of the Omnibus Reconciliation Act of 1980, which provides coverage of comprehensive outpatient rehabilitation facility (CORF) services.

I do not believe that we have the authority to publish final regulations at this time, as you suggest. Under the Administrative Procedures Act, government agencies are required to publish proposed regulations in the Federal Register under the rulemaking process, giving interested parties an opportunity to submit written data, views and arguments. The express purpose of this process is to encourage public participation in the development of government policies. The agency may dispense with proposed rulemaking only for good cause, that is, if the publication of proposed rules is impracticable or unnecessary or would be contrary to the public interest. We have from time to time dispensed with proposed rulemaking, but this practice has been confined to such situations, for example, as those involving technical changes or those where the regulations specifically implement, with little Secretarial discretion, a provision of law. This is not the case with the CORF legislation.

Although the amendment redefines "provider of services" to include CORFs, it expressly requires that CORFs meet certain conditions regarding the qualifications of personnel and other conditions which the Secretary finds necessary to protect the health and safety of CORF patients. Also, while the amendment specifies particular services that are to be covered as CORF services, the Congress did not provide definitions of these services or specific utilization parameters. Because delivery of services by CORFs is a new concept under Medicare, we believe that policies governing both conditions of participation and conditions of coverage must be published under the rulemaking process so that providers and beneficiaries have a clear understanding of our views and to allow interested parties to contribute to the development of CORF policies.

Page 2 - Mr. James A. Cox, Jr.

We do appreciate your concerns, however, and assure you that we are moving ahead with our implementation plans. Our schedule calls for publication of the proposed regulations in the Federal Register by January 1982 with a 60-day period for public comment. We will publish final regulations and operating procedures as quickly as possible after the comment period has closed so that qualified CORFs may be reimbursed for covered services. As you indicate, this means that implementation of this provision will not occur until sometime next year. While we understand your displeasure, we do not believe that HCFA could develop a convincing argument to justify dispensing with the rulemaking process.

Sincerely yours,

Patrice Hirsch Feinstein

Patrice Hirsch Feinstein
Associate Administrator for Policy

ATTACHMENT 4

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

NOV 28 1981

NOV 25 1981

RECEIVED
NOV 30 1981
WAYS AND MEANS
HEALTH SUBCOMMITTEE

The Honorable Andy Jacobs, Jr.
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Jacobs:

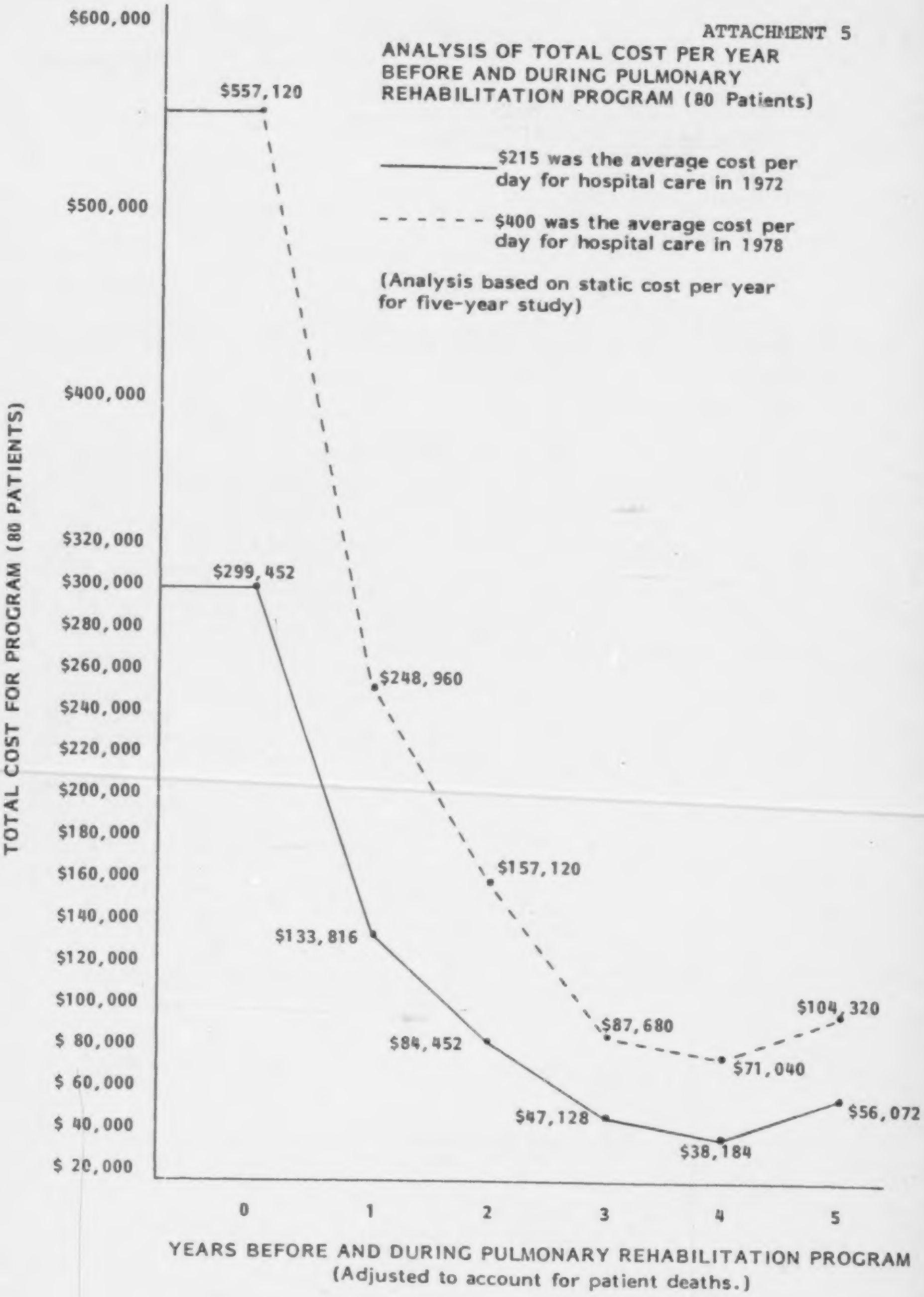
Thank you for your letter of September 19, 1981 concerning implementation of Section 933 of P.L. 96-499, the Omnibus Reconciliation Act of 1980, which provides for coverage of comprehensive outpatient rehabilitation facility (CORF) services under Part B. of Medicare.

The regulations to implement this provision are nearly completed, and we expect to publish proposed conditions of participation and conditions for coverage of services in the Federal Register by January 1982 as a Notice of Proposed Rulemaking with a 60-day period for public comment. Because delivery of services by CORFs is a new concept under Medicare, we want to be sure that our policies are consistent with established rehabilitation care practices. We believe it is essential to obtain comments from the public prior to publication of final regulations. As soon as the comment period is closed, we will publish final regulations and operating procedures and begin reimbursing qualified CORFs for covered services.

We further believe that regulations are necessary before we can start paying benefits under this amendment. Although the amendment redefines "provider of services" to include CORFs, it also expressly requires that CORFs meet conditions of participation that the Secretary finds necessary in the interest of health and safety of patients, including conditions concerning the qualifications of personnel in CORFs. Moreover, while the amendment specifies particular services that are to be covered as CORF services, the Congress did not provide definitions of these services or specific utilization parameters. We believe that the policies governing both conditions of participation and conditions of coverage must be published in regulations not only to give providers and beneficiaries a clear understanding of our policies, but also to allow the public to comment, thereby contributing to the development of those policies.

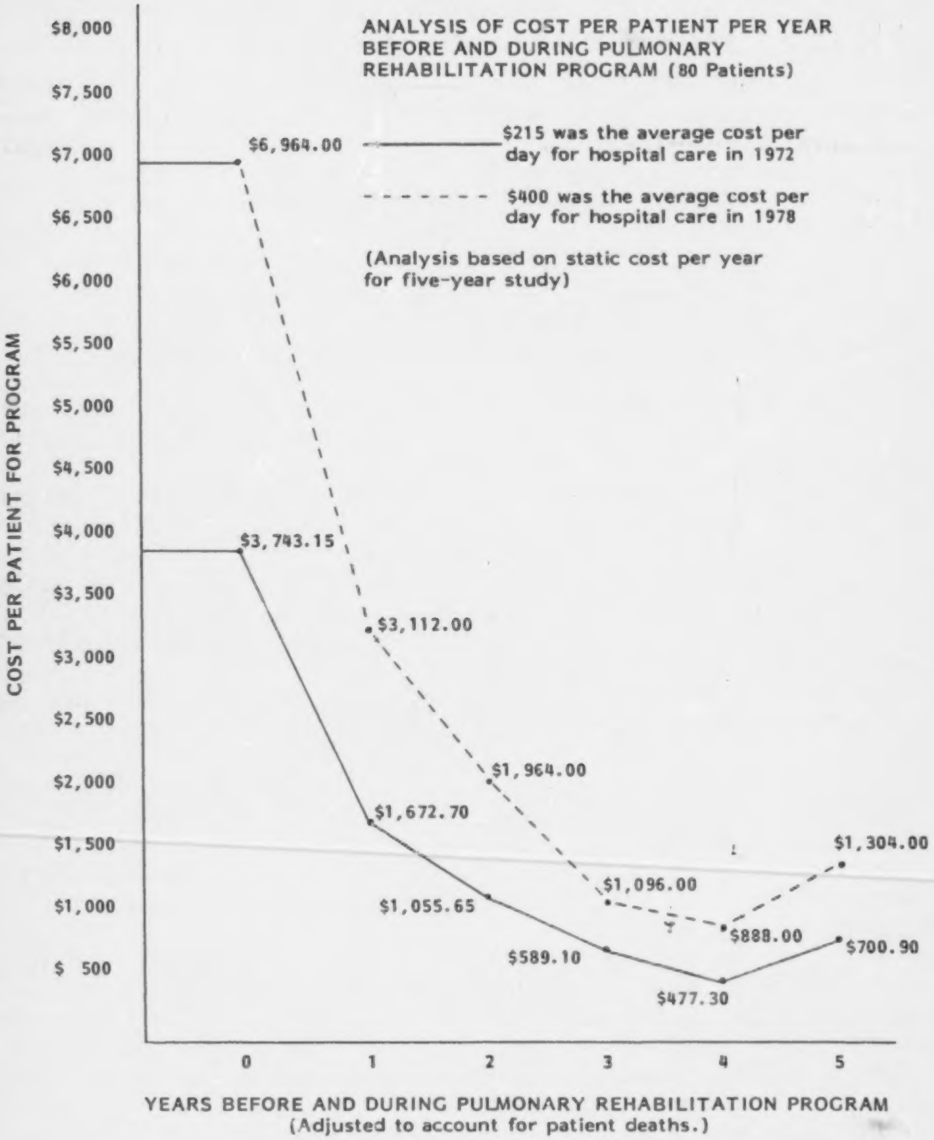
Sincerely,

Richard S. Schweiker
Secretary



ATTACHMENT 5

ANALYSIS OF TOTAL COST PER YEAR BEFORE AND DURING PULMONARY REHABILITATION PROGRAM (80 Patients)


ANALYSIS OF COST PER PATIENT PER YEAR BEFORE AND DURING PULMONARY REHABILITATION PROGRAM (80 Patients)
$215 was the average cost per day for hospital care in 1972
$400 was the average cost per day for hospital care in 1978
(Analysis based on static cost per year for five-year study)
COST PER PATIENT FOR PROGRAM
$8,000
$7,500
$7,000
$6,500
$6,000
$5,500
$5,000
$4,500
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$ 500
$6,964.00
$3,743.15
$3,112.00
$1,964.00
$1,672.70
$1,055.65
$1,096.00
$589.10
$888.00
$477.30
$1,304.00
$700.90
0
1
2
3
4
5
YEARS BEFORE AND DURING PULMONARY REHABILITATION PROGRAM
(Adjusted to account for patient deaths.)

STATEMENT OF FRANCIS J. MALLON, ASSOCIATE EXECUTIVE DIRECTOR FOR PROFESSIONAL SERVICES, AMERICAN PHYSICAL THERAPY ASSOCIATION, WASHINGTON, D.C.

Mr. MALLON. Mr. Chairman, my name is Frank Mallon, and I am the associate executive director of the American Physical Therapy Association. On behalf of the association and its 40,000 members, I appreciate the opportunity to offer brief comments on President Reagan's budget proposal related to the medicare program.

My testimony concerns specifically the proposal in the President's budget to roll back the limit on reimbursement for services provided by independent practicing physical therapists. At the present time this limit is set at $500 per person treated per year. The budget proposal would reduce this limit to $100 per person per year.

This provision applies only to individuals who participate in part B of the medicare program. Actual reimbursement, therefore, is set at 80 percent of the allowable limit.

Let me briefly summarize the history of this particular provision. In 1972 the medicare law was amended to permit reimbursement for physical therapists in independent practice up to a limit of $100 per person treated per year. In 1980 the medicare law was again amended to raise the limit to $500. In 1981 the President's budget proposal requested a return to the $100-limit. Congress considered and rejected the repeal proposal.

In 1982 the President's budget again requests the return to the $100 limit. Once again, we strongly urge you to leave the $500 limit intact.

Physical therapy is an important part of the health care provided to medicare beneficiaries. Persons with fractured limbs or hips, individuals who have suffered strokes and heart attacks, and others with severe physical disabilities—muscle strains, nerve damage and joint problems—both need and benefit from this service.

The $500 limit on independent practitioner coverage increases the availability of this necessary care since it permits coverage for treatment in the physical therapist's office or in the patient's home. Since treatment in these settings tends to cost less than in other settings, moreover, the $500 provision also serves as an incentive for shifting the treatment setting to one in which there is a more cost-effective provision for physical therapy care. These cost savings might well eliminate the relatively small initial cost of $4 million which has been projected as the 1983 cost of this benefit.

It is important to remember that this $500 provision represents no new benefits but merely a realistic attempt to bring a benefit which has existed since 1972 into line with the 1982 cost of health care. To revert back to the 1972 $100 limit would, for all practical purposes, serve to wipe out the benefit entirely with the end result that persons needing physical therapy could only be treated in settings where the costs are higher.

Finally, it should be noted that safeguards exist to insure proper utilization of this service. Physician certification of initial and continuing need, documentation of patient status, and standards for qualified practitioners continue in effect.

The current $500 limit on reimbursement for physical therapy provided by independent practitioners represents a modest and a reasonable effort to maintain the quality of the medicare program in a cost-effective manner.

We strongly urge your support of this effort and your assistance in insuring that Congress will reaffirm its position of 2 years' standing on this issue.

Thank you, Mr. Chairman.

[The prepared statement follows:]

March 16, 1982

WRITTEN STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION ON PRESIDENT REAGAN'S PROPOSED BUDGET FOR HEALTH CARE SERVICES

On December 5, 1980, the Omnibus Reconciliation Act of 1980 became law. Section 935 of that Act raised the Medicare reimbursement limitation on outpatient physical therapy services from $100 to $500 -- the only increase in the limitation since it was established in 1972. Last year, President Reagan recommended repeal of this increase as part of his budget revision package. Congress refused to enact the repeal, concluding that the increase was necessary to ensure the provision of needed physical therapy services to Medicare beneficiaries. President Reagan has again proposed repeal of the higher limit in his Budget for Fiscal Year 1983.

The American Physical Therapy Association ("APTA"), which represents approximately 40,000 physical therapists and physical therapist assistants nationwide, enthusiastically supported enactment of the increased limitation and vigorously opposed President Reagan's effort to have it repealed. APTA believes that there are several compelling reasons why President Reagan's proposed repeal of §935 should be rejected again this year.

First, the increase in the outpatient limit to $500 is an extremely small cost item which will not "bust the budget" if it remains in force. At a maximum, the increase will cost only an estimated $4 million this year and $5 million in fiscal years 1983-1985 or approximately .0068% of the $72.7 billion proposed by President Reagan for the health care services budget. It should also be noted that the potential for over-utilization of services or a large increase in costs to the Medicare program due to the limit increase is minimal because physical therapy services can be furnished only pursuant to a physician's referral and actual referrals are not expected to increase substantially.

The insignificance of this provision relative to the health care services budget vastly understates its importance to Medicare beneficiaries and physical therapists who render services on an outpatient basis. As explained below, a return to the $100 limitation would deprive beneficiaries of needed physical therapy treatments and would prevent physical therapists from furnishing services in and efficient and economical manner.

Second, repeal of the increase would, in effect, legislate outpatient physical therapy services out of the Medicare program. If President Reagan's proposal were accepted, no more than $100 in any calendar year could be considered as reimbursable incurred expenses for outpatient physical therapy services furnished by a therapist in independent practice. The $100 could be reduced further by the deductible and coinsurance provisions of Part B of the Medicare program.

Inflation in medical costs since the $100 limit was imposed in the Social Security Amendments of 1972 has significantly reduced the amount of services which can be provided to Medicare beneficiaries for $100. Because physical therapy care generally consists of a series of treatments (as opposed to a single visit), a $100 limit would prevent patients from initiating or completing prescribed therapy programs unless they had access to more costly provider facilities where the $100 limit would not apply. Homebound patients, particularly older Americans and persons who reside in rural areas who do not have ready access to provider facilities would be most adversely affected by a return to the $100 limit because independently practicing therapists are their only source of needed care.

The following examples of typical treatment plans illustrate the gravity of the hardships which will result if the outpatient limitation is cut back to $100.

> Example One: A typical physician prescription (physical therapy treatments are furnished only when prescribed by a physician) for physical therapy treatment for an individual who has suffered a serious strain or hyperextension of the lower back would provide for three treatments per week for three weeks. Each treatment would likely include five modalities: traction, ultrasound, therapeutic exercise, massage and application of hot packs. Each such treatment would last approximately an hour and fifteen minutes and would cost about $26.00. Therefore, the total cost for nine treatments would be $234.00. Under a $100 limitation on outpatient physical therapy services, Medicare would reimburse the beneficiary $100, assuming that the $80.00 deductible has already been covered. The patient would be personally responsible for payment of $134.00.
>
> Example Two: Assume that an elderly woman has suffered an arm fracture in a fall. The normal physical therapy program prescribed by a physician in such a case would be for three treatments per week for six weeks. Each treatment would usually consist of three modalities: therapeutic exercise, ultrasound, and whirlpool. Each treatment would last approximately an hour and would cost around $22.00. The total cost of the program of care would be $396.00. Under a $100 limitation scheme, Medicare would cover $100 and the elderly woman would be liable for the remaining $296.00.

> Example Three: For stroke victims, it is common for a physician to prescribe thirty-six physical therapy treatments over the course of three months. Each treatment would consist of a single procedure: exercise of individual muscle groups, gait training, etc. The normal time for such treatment is generally forty-five minutes and typically costs in the neighborhood of $27.00. The total cost for this plan of treatment would be $972.00, $872.00 of which would have to be paid by the Medicare beneficiary if a $100 limitaion were in effect.

In the experience of APTA's members, the existing $500 limitation allows the majority of prescribed programs of care for most illnesses or injuries to be completed without financial hardship to Medicare beneficiaries. Any limit less than $500 would precipitate a manifold decrease in the amount of outpatient physical therapy case that a Medicare beneficiary could obtain.

Third, the $500 limitation increases access to physical therapy provided in less costly settings and, therefore, contributes to the overall reduction of Medicare costs. There is no dollar limit on reimbursement for physical therapy provided in hospital and nursing homes, both inpatient and outpatient, or in physicians' offices. Physical therapy provided in these settings, however, costs significantly more than when provided by the independent physical therapist on an outpatient basis. By encouraging treatment in less costly settings, therefore, the $500 provision promotes a cost-effective health care system.

APTA strenuously opposed the Administration's proposal to repeal the $500 limitation on outpatient physical therapy care. The critical need for the increase was well documented by the 96th Congress and reaffirmed last year when it refused to accede to President Reagan's request that it be repealed. APTA urges Congress to preserve the increase in the dollar limitation which it has laboriously considered, approved, and maintained over the last three sessions of Congress.

The CHAIRMAN. As I understand it—physical therapy is currently covered as an inpatient and outpatient hospital service, a rehabilitation service, and as a home-health service. So it is not as if the services are not available under the medicare program.

I guess you have just addressed part of the question, but wouldn't it be more efficient and less costly for physical therapists to provide their services out of one of these organized settings rather than under the special provision which pays for these services in the physical therapist's private office?

Mr. MALLON. From what information and data that we have been able to gather, Mr. Chairman, the difference in the overhead cost actually makes it cheaper to provide this service in the physical therapist's office. Obviously, if you have a physical therapist working alone or with two or three other physical therapists, the administrative and the overhead costs that will attach to the service are much reduced. Likewise, it affords the opportunity, and this is especially true in rural areas, to provide more extended coverage in the home setting, which is also permitted under this provision.

For these reasons, then, it really would not be more cost effective to force a return to an institutional setting on each occasion that physical therapy is needed. The ability to provide this service in a therapist's office, therefore, does have a very cost-effective element to it.

The CHAIRMAN. Well, I don't know what information or what surveys you have, but it might be helpful to our staff if you would provide it.

Mr. MALLON. We would be glad to do that.

[The information follows:]

american physical therapy association

1156 15th STREET, N.W., WASHINGTON, D.C. 20005 • (202) 466-2070

April 1, 1982

Honorable Robert J. Dole
Chairman
Senate Finance Committee
2227 Dirksen Senate
  Office Building
Washington, DC 20510

Dear Mr. Chairman:

At the end of my testimony, Mr. Chairman, you requested information which had been brought to our attention regarding the cost effectiveness of physical therapy provided by independent practitioners. The Attachment to the letter contains excerpts from testimony provided by the United Societies of Physiotherapists, Inc. at Hearings before the Subcommittee on Health of the House Committee on Ways and Means on March 30 and 31 and April 1, 1981 ("Proposed Budget Cuts In The Medicare Program" Serial 97-20). The study of Blue Cross/Blue Shield data reported by the United Societies indicates that, on the average, the cost of physical therapy furnished by independent practitioners was $43 less than the cost of the service furnished by an institutional provider. The testimony then goes on to address the cost savings which can realistically be expected if access to services provided by independently practicing physical therapists is made more available.

I fully recognize that hard data on the comparative cost of physical therapy provided by independent practitioners as opposed to institutions is not in abundant supply. I am sure that this was the primary reason for Congress' request of the Secretary of Health and Human Services "to collect and submit data on the costs of physical therapy services provided by physical therapists in independent practice." (Report of the House Committee

Senator Robert Dole
April 1, 1982
page two

on the Budget accompanying the Omnibus Reconciliation Act of 1980, Report No. 96-1167, p. 387). This section of the report, which also accompanied the enacted legislation, went on further to stipulate that "in submitting such data, the Secretary will include national comparisons of costs for physical therapy services furnished by independent practitioners and the cost of such services when provided in all other settings covered under the Medicare program."

I should point out that the cost comparisons reported in the Rochester study noted in the Attachment correspond closely with the reports which we receive from physical therapists nationally. The major reason cited by these therapists for the cost difference is the absence of the substantial administrative and overhead costs which institutional providers must carry. The independent practice setting, moreover, is not subject to the type of cost shifting which frequently occurs in institutional settings where revenue-producing centers are used to support areas where less revenue is generated.

I would also like to emphasize, in response to your original question concerning the need for coverage of the independent practitioner, that access to care is a most important consideration. The independent practitioner makes it possible for individuals, who might otherwise have to seek some form of institutional care, to be treated in their homes or in the community at the physical therapist's office. Transportation to the site where care is provided is a serious concern to elderly persons. The availability of physical therapy in the home and private office reduces this concern to some extent. Coverage of the care in these settings, therefore, is an important complement to the coverage provided for institutional-based care.

I hope this information responds satisfactorily to your request. In brief, cost-efficiency and improved access to needed care are the primary reasons for retaining the $500 limit on reimbursement for services provided by physical therapists in independent practice.

I appreciate the opportunity to provide this additional information in connection with my testimony.

Sincerely.

Frank Mallon

Francis J. Mallon, Esq.
Associate Executive Director
Professional Relations Division

FJM/klf

Enclosure

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Excerpt of Statement of Alan Leventhal, PT, on Behalf of the United Societies of Physiotherapists, Inc.

Because of the lack of cost data, the United Societies has attempted to collect cost data on the average cost of a visit to an institutional provider and to a private practitioner. Because of our limited financial resources we were able to study only one regional area (the six county Rochester, New York region). We conducted two separate studies. The first study conducted in preparation for out testimony at the June 27, 1979 hearings used Blue Cross/Blue Shield data for the Rochester region. We examined all Blue Cross/Blue Shield outpatient physical therapy claims (9,561 claims) for the region for the preceding eighteen month period. The data revealed that the average cost of a visit to an institutional physical therapy facility was $61.64. In contrast, the average visit to a private physical therapist cost approximately $20. Recently, more extensive data gathering has been conducted, which further demonstrates the savings potential possible through expanded use of private physical therapists. In the Rochester, New York area cost data has been gathered for 14,360 physical therapy visits for the period from January 1, 1978 to June 1, 1980. This data represents every physical therapy treatment provided by an institutional provider and paid for by Blue Cross/Blue Shield. This data base is one of the most comprehensive available anywhere on the subject. From that data, a sample was selected to provide a confidence level of 95 percent is an expected error rate of less than ±3 percent (see Table I below).

TABLE I.—*United Societies of Physiotherapists, Inc., Physical Therapy Data Base, June 1980*

Source: Blue Cross/Blue Shield, Rochester, New York.
Sample Area: Six County Upstate New York Region.
Data: 14,360 individual claims paid by Blue Cross for institutional outpatient physical therapy treatments.
Period Covered: January 1, 1978 through June 1, 1980 (30 months).
Sample Size: 361 data points selected at random.
Confidence Level: 95 percent.
Expected Error Rate: ±3 percent.
Mean (Average) Cost Per Treatment: $62.81.
Range: Low $4.00, High $599.00.
Memo: The average cost of a treatment provided by a private practitioner in the same geographic area for the same time period was $20 per treatment.

The data shows that the average cost of a visit to an institutional provider for this period was $62.81. Again, in contrast, the average cost of a private physical therapy treatment was approximately $20. This data base confirms the fact that an institutional physical therapy visit is, on the average, three times as expensive as a visit to a private therapist.

However, as stated earlier, current medicare law often forces the elderly patient to choose the higher cost institutional provider because most, if not all, of the treatments will be covered by medicare if rendered by the institutional provider. Current law, therefore, penalizes both the patient and the medicare system. The medicare system is burdened by much higher costs. The patient is restricted in his choice of a physical therapist. In essence, the patient cannot freely choose his physical therapist, which may result in reduced patient satisfaction and, perhaps, reduced quality of care.

The recently enacted provisions of Public Law 96-499 will allow a patient to be reimbursed for the first $500 of private physical therapy care and will permit a patient, in many instances, to be treated by a therapist of his choice. This should result in the patient choosing to switch from a higher cost institutional provider to a lower cost private practitioner at a considerable savings to the medicare system. In addition, the $500 provision will allow more patients to receive needed physical therapy care. Presently there are many situations where an elderly patient cannot obtain needed physical therapy care from an outpatient clinic or through a home health agency. For example, in many rural areas, the local hospital does not have a physical therapy department and the area is not served by a home health agency. In these circumstances the patient is often reluctant to start a program of treatment that will have to be terminated after only five visits because of the current $100 limitation. The $500 limit, which will go into effect January 1, 1982, will provide on the average up to twenty-five visits and will, consequently, enable more patients to receive needed care.

It is important to note that even though the $500 limit will enable more of our elderly to receive needed care, total physical therapy costs to medicare will, in all likelihood, be reduced or remain the same. This is true because for every patient that switches from an institutional provider (at $62.81 per visit) to a private practitioner (at $20 per visit) two additional patients with problems of similar severity can be treated at no additional cost to the medicare system.

In addition, if we assume that as a result of the new $500 limitation, 20 percent of the patient visits for physical therapy treatment (out of an assumed total of one million) shift from institutional providers to private practitioners, we would see a net savings of $42.81 per shifted treatment or $8.6 million. If 25 percent of treatments shifted from institutional to private practice, savings would top $10 million. This conclusion is based on very limited data. However, all the data available, from private sources, GAO and HHS supports this conclusion.

"Proposed Budget Cuts in the Medicare Program," Hearings Before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, Ninety-Seventh Congress, First Session, March 30, 31; April 1, 1981, Serial 97-20

The **Chairman**. Mr. Spang, the same with you. I don't have any specific questions, but it might be helpful if you would touch base with our staff.

Mr. **Spang**. We will certainly do that, Mr. Chairman. Thank you.

The **Chairman**. And, as I have indicated, your statements will be made a part of the record.

Thank you.

Mr. **Spang**. Thank you, Mr. Chairman.

Mr. **Mallon**. Thank you, Mr. Chairman.

The **Chairman**. We next have a panel consisting of Mr. John Abbott, president of the National Council of State Child Support Enforcement Administrators; and Mrs. Betty Hummel, administrator, child support enforcement program, Kansas State Department of Social and Rehab Services, Topeka, Kans.

STATEMENT OF JOHN P. ABBOTT, PRESIDENT, NATIONAL COUNCIL OF STATE CHILD SUPPORT ENFORCEMENT ADMINISTRATORS, SALT LAKE CITY, UTAH

Mr. **Abbott**. Mr. Chairman and distinguished members of this committee, it is indeed a pleasure for us to be here this morning.

I am John Abbott. I am the current president of the National Council of Child Support Enforcement Administrators. I am here today representing the 54 States and jurisdictions in a matter that was presented before this committee last week. Last week, I believe, you did hear from Secretary Schweiker in regards to the child support enforcement program and a budget-cutting proposal that has been proposed for that program.

I am here today to speak to this issue and indicate why we do have some concerns nationally about these cuts.

Essentially we believe that you currently have a very cost-effective program nationally. Over the years of our existence the program has collected $6 billion at a cost of around $2 billion. That is not counting last year, when $1.6 billion was collected at a cost of a little over $500 million.

We believe that the program is presently cost-effective and that the $191 million deficit that Secretary Schweiker referred to last week has really been over-projected due to miscalculations on the potential of the IRS tax-intercept program.

As you may know, the Omnibus Reconciliation Act of 1981 made law a tax-intercept program wherein delinquent payers of child support could have their income tax refund intercepted and applied to their child-support debt.

Conservative estimates—we think very conservative—by the Department of HHS indicate approximately $100 million will be recovered this year from that initiative. Based on our calculations, we believe that the real number is closer to $500 million and that certainly no less than $300 million will be recovered from this effort.

We state this due to the fact that there are 550,000 cases that have been identified in this matchup; and as you may have read in the paper on several occasions, this amounts to about a $2 billion total pool of money out there. We don't believe that a 25-percent tapping of that resource, which would net out at $500 million, is unrealistic at all.

Second, you heard last week that this formula approach to funding the child support program would lead to increased cost effectiveness and efficiency. What we believe has not been taken into consideration in this approach is the enforcement aspect of this program nationally. Right now you have a nationwide network of child support enforcement agencies that are cooperating with each other. You have a situation where individuals cannot go across State lines and avoid payment of their child support obligation.

If you establish this restructuring proposal, this formula approach to funding, we believe that you will seriously jeopardize that part of the program. In fact, the formula as currently constituted provides no incentive whatsoever for the States to enter into interstate enforcement of support obligations.

Additionally, the costly, protracted court involvement often involved in paternity establishment is ignored. Currently, 17 percent of our births in this Nation are born out of wedlock; yet, with the elimination of this phase of the program that the formula essentially assures, what is going to be the future of all of those children who are born out of wedlock at this time?

Third, we believe that the non-AFDC effort has been avoided in this particular proposal. It has been estimated that anywhere from $244 million to $324 million are saved annually as a result of this non-AFDC effort. While the new proposal addresses the costs of this program, it does not count at all the benefits.

Therefore, in conclusion, Mr. Chairman, we would hope that this committee might study this program on its merits and reject this proposal that has been offered.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE NATIONAL COUNCIL OF STATE CHILD SUPPORT ENFORCEMENT ADMINISTRATORS BY JOHN P. ABBOTT, PRESIDENT

Introduction

Mr. John P. Abbott is appearing before the Senate Finance Committee to express the views of the National Council of State Child Support Enforcement Administrators in relation to the fiscal year 1983 Administration budget proposal as it affects Child Support Enforcement. Mr. Abbott is the current President of the National Council and is Director of the Office of Recovery Services, the parent organization for Child Support Enforcement in the State of Utah.

The National Council of State Child Support Enforcement Administrators is an organization which promotes the development of legislation or policies that will have positive impact upon the Title IV-D Child Support Enforcement Program. It is also an organization which is concerned with interstate and international relationships in the enforcement of child support obligations. Finally, the National Council provides a forum and structure to be used for communication and resolution of common problems and to act as a unified body for representation in matters of national concern.

The National Council is composed of representatives of each state and the territories within the United States. Each of the 54 jurisdictions maintains membership. (A listing of these representatives may be procured by written request to the National Council.) The membership has been canvassed and each has had an opportunity to express its views in the matter before the committee.

There is concensus from the membership that the views expressed herein are accurate representations of the concerns jurisdictions hold with the basic tenets of the restructuring proposal contained in the Fiscal Year 1983 Administration budget recommendations as they relate to future funding to the states for Child Support Enforcement activity.

History of Child Support Enforcement

The history and evolution of the Child Support Enforcement program has taken many years to unfold. The dynamics can be traced back to the changing social and economic factors of our nation and its people.

At its roots the question must be asked, whose obligation is it to support children? Common law seemingly failed to impose on the father a civil obligation to support his child(ren). For example: As late as 1953, the Supreme Court of New Jersey had difficulty finding a legally enforceable support obligation which bound the father to his child(ren). The need was so basic -- but the remedy only referenced "natural law."

Viewed as a state and local problem for many years, Federal attention was attracted to this area of law as costs in the Aid to Families with Dependent Children (AFDC) program continued to escalate. Inadequate laws were producing low returns of child support collections while 70-80% of those receiving AFDC assistance were eligible due to the nonpayment of child support obligations. Aggravating this neglect was the ideological dislike of support enforcement that sprang from a spreading notion that the state, rather than the absent father, should support abandoned children by means of the AFDC program.

Senator Russell Long, then Chairman of the Senate Finance Committee, and Representative Griffith, then Chairwoman of the Subcommittee on Fiscal Policy of the Joint Economic Committee, developed and published a thoughtful analysis of the welfare system. Both were dedicated to the cause of comprehensive child support enforcement practices. The states' failure necessitated national action to establish umbrella enforcement laws. Congress finally moved to strengthen the enforcement of child support obligations and thereby sought to reduce the cost of AFDC benefits. Effective August 1, 1975, sweeping amendments changed the AFDC title of the Social Security Act and a new Child Support Title (IV-D) was added. During the intervening years nationwide enforcement has been initiated, and while the cost of the AFDC program has continued to grow, most practitioners in the field and studies of the program indicate that the growth would have been substantially greater without the cost-avoiding effects of the Child Support Enforcement program.

Since the late 1950's, the AFDC program growth rate has increased every year. That growth is directly attributable to the escalating incidence of divorce, marital separation and out-of-wedlock births. The custodial parent, usually the mother, is faced with a financial crisis and seeks financial assistance through governmental outlets. Since most potential AFDC clients enter the work force at or below the minimum wage level, they often find their incomes insufficient to meet ordinary household expenses, not including day care, clothing and transportation expenses attributable to working. Often times the burdens of daily work, the responsibility of being the only decision maker in the household and having the complete responsibility for raising the children, overwhelms the custodial parent. These factors, coupled with the lack of financial support from the absent parent, places the custodial parent in a position of financial dependency upon governmental programs.

The incredible growth in AFDC expenditures of over 20 times in 22 years has had a significant impact on all of us. Numerous debates have ensued as to whether it is society's responsibility to support these families and the issue has never been resolved. Most Americans believe, however, that it is a worthwhile cause to extend help to needy children. At the same time, they feel that government has an obligation to minimize the taxpayer burden that results from aid programs.

At present, national estimates indicate one out of every three marriages in the United States ends in divorce. There appears to be a direct correlation between the increasing divorce rate and the increase in the number of welfare families with a single parent heading the household. In fact, 78% of all welfare households in this country consist of a single parent, generally a woman, attempting to support her children in large part (95%) because the husband or father has absented himself and withdrawn his financial support from the family. The woman, in an attempt to support her children without the income of the husband, has usually applied in desperation to the state welfare office requesting assistance for herself and the children. In other words, when fathers default and avoid their parental responsibilities, the chance of their children being supported by a governmental aid program is much higher. Before going on, it should be pointed out that there are a large number of absent parents that are responsible for making all of their child support payments. Many of these absent parents do make regular, child support payments. In these cases normal visitation rights are generally exercised and the children can share a relationship with both parents. A multitude of problems are avoided when the separated parents maintain a non-hostile relationship. This is usually possible only when the custodial parent receives regular financial support from the absent parent.

How serious is this problem of non-support of families by irresponsible parents? Over 7 million children are presently receiving public assistance in the United States through the various state welfare programs, which are generally funded over 50% by the Federal government. Of even greater concern is the possibility that the very existence of the welfare program has caused some of these fathers to conclude that if they have marital difficulties, they need not worry about the consequences of leaving their families because the government will provide assistance while they go out and establish new lifestyles, and perhaps father other children. This situation is economically unacceptable, and we must find a solution which will eliminate or at least significantly reduce the problem.

There is another significant factor which has contributed to the increased growth of the welfare program (AFDC). That factor is the number of children born out of wedlock. According to statistics maintained by the National Health Center there were, in 1979, an estimated 597,800 out-of-wedlock babies born in America, accounting for approximately 17% of all births. This is more striking when compared to statistics of a decade ago. In 1970, unwed mothers had 399,000 babies, 10.7% of all births for that year. The 50% increase in illegitimacy stems at least in part, from the current lack of stigma associated with out-of-wedlock births. It was thought that the increased accessibility to contraceptives and abortions would curtail the out-of-wedlock birth trend. However, there are 6.4 million more women of childbearing age in the United States now than 10 years ago, an increase of 4%. At the same time, childbearing by unmarried women increased 6.1%. The Urban Institute of Washington, D.C., clearly indicates that the propensity for unwed mothers to keep and raise out-of-wedlock children is rising. The Office of Child Support Enforcement reports that the stunning increase in the non-marital birth rate has brought a corresponding increase in the cost of AFDC funding. More and more the mothers of these children refuse to marry the natural fathers, and when postnatal marriage does occur, at least one in three will subsequently end in divorce. With the father absent from the home, the burden of support shifts to government sponsored programs, paid for by tax revenues from various sources.

Census figures indicate that there are over 46 million families in the United States of America that are not receiving welfare. Every one of those families is being asked to bear a part of the support burden for these 7 million children who are receiving welfare. The absent parent may be quite capable of providing the needed support for his children. However, he has usually defaulted on his obligation of his own volition and withheld his support.

In the early stages of the welfare program, little was done by Congress or the states to recoup the welfare dollars expended. Over the years, policy statements were made in which the intent to recover monies expended was defined, but there was very little interest by the states in setting up programs to recoup those monies. The apparent reason for this reluctance was that the cost of setting up a recovery program seemed prohibitive. As a result of this lack of action, many absent parents became remiss in their obligation to support their children and were, for a considerable period of time, not made to bear the costs of supporting their children. Society simply "picked up the tab," but the tab has become incredible. In 1956, the total cash benefits expended in assistance to children was just over $617 million. By 1979, 22 years later, that figure increased to an astounding $12 billion annually. As staggering as that figure sounds, it is not all-inclusive. Additional billions were spent on food stamp and medicaid. Two questions need to be addressed: "Why should taxpayers be required to bear the costs of supporting the children of the financially capable, but irresponsible parent?" and "How do we reverse this irresponsible pattern established by absent parents?"

Federal participation in child support began in 1975 with the enactment of Title IV-D of the Social Security Act (P.L. 93-647). Maintaining a child support program became an individual state eligibility requirement to receive federal match grant funding in the AFDC Program. Federal financial participation was provided for 75% of the administrative costs of running the child support program. The remaining 25% would be provided by the state and/or local government.

There are two types of collections and disbursements involved with the child support program. Both facets of this program are mandatory and all states participate in both to widely varying degrees. First, collections are made for individuals receiving AFDC which are distributed back to the state and federal governments for subsequent disbursement to be applied against AFDC costs. These collections are distributed between the two based upon the matching grant rate which the federal government provided to each state's public assistance program. This rate varies between states, and ranges from a 50/50 to 77/23 federal/state split. Second, collections are made for individuals who are not receiving AFDC. These are sent directly to the custodial parent. Neither the state nor the federal government receives any portion of these collections, but the collections significantly reduce the potential for AFDC eligibility in many cases. We have been told that in the Sixth Annual Report to the Congress, the statement is made that $244 million in cost avoidance has been saved through the Non-AFDC support enforcement programs by the Department of Health and Human Services, Office of Child Support Enforcement.

To encourage cooperation between the various states and political jurisdictions the federal government has also provided for a 15% incentive payment on AFDC collections made by one jurisdiction for another. This 15% was taken out of the federal share of collections. In addition to establishing standards for child support unit operations, the nationally based Office of Child Support Enforcement has promulgated regulations covering the maintenance of case records, the establishment of paternity, the locating of absent parents, the enforcement of support, and the use of cooperative agreements among the states. The operation of the program is left to the state child support units which are required to function within the parameters of local law; some under state statute, others under county prerogatives.

In 1980, $603 million was recovered from the parents of children receiving AFDC. While this recovery effort represents a step in the right direction, many barriers still exist which prohibit effective and efficient child support collections. The problem has primarily been one of a lack of laws to deal with the 30-50% of absent parents who cross state lines to avoid payment of support. Nationally, only 11.3% of the absent parents whose children receive AFDC are actually paying child support. If that 11.3% average could be doubled, the total amount recovered would be nearly $1.2 billion per year. Reliable data now exists which indicates that the figure can be doubled. A number of states are already receiving payments on over 20% of their cases.

As the program has grown there is no doubt that the Federal matching of 75% and financial incentives of 15% have assisted states and jurisdictions to launch programs which are curtailing the growth rate of AFDC. This is particularly true in low grant states, where thousands are removed from the AFDC roles monthly as a direct result of child support enforcement efforts. Other elements, such as the establishment of paternity and interstate cooperation, are also beginning to receive the attention they deserve. These accomplishments demonstrate that continued support at the national level will result in future growth and success in the program.

The most current published information demonstrates the effectiveness of the program. This data has been extracted from the 5th Annual Report to Congress, published by the Department of Health and Human Services, Office of Child Support Enforcement. The primary areas of focus used in this exhibit are examples of the positive financial and social impacts upon the population, particularly the children of the nation.

	Total Child Support	AFDC Collections	Non-AFDC Collection	Paternity Establishments
1976 -	$ 512 million	$204 million	$308 million	14,706
1977 -	864 million	423 million	441 million	68,263
1978 -	1,048 million	472 million	576 million	110,714
1979 -	1,333 million	597 million	737 million	117,402
1980 -	1,478 million	603 million	875 million	144,467

It is worthwhile to note that funds collected in the Non-AFDC category are refunded directly to families not on public assistance. It is estimated that of these families, 22% or more would be on public assistance if the collection service were not in place. This translates into a substantial savings in AFDC, food stamp, and medical assistance expenditures and is part of the basis for the estimate that $244 million was saved last year through these efforts.

The AFDC collections are distributed back to the state and federal governments in proportion to the AFDC participation rates. These monies help to offset the direct costs of the public assistance programs. The growth of the return has been 296% from 1976 to 1980.

Given the dramatic rise of illegitimate births in the nation, it is becoming increasingly important to establish paternity for as many children as possible. The success in this program helps children in many ways. Establishing paternity for children, that is, legally identifying the father, helps to eliminate the stigma associated with lack of paternity. It also establishes potential social security and veteran's benefits and potential inheritance rights. Since the first year of the Title IV-D program, the increase of 982% in this area serves as an excellent example of the programs long range impact to society.

Future Prospects

With a description of the history and successes of the Child Support program having been given, the issue at hand is the financial restructuring proposal currently being advocated by the Administration in their 1983 budget proposal.

The financial restructuring proposal, as it is understood at this time by this organization, is a drastic departure from the funding base that has helped us achieve the current measure of success. We believe that the inroads that have been made to further enhance the program will be in serious jeopardy should the restructuring proposal be adopted.

The current Federal Financial Participation (FFP) rate allows for 75% federal reimbursement for costs incurred in the efforts to collect child support by the state or local government whether intra-or interstate.

In addition to the 75% FFP, the Congress has seen the need to create an incentive program for counties and states for having aggressive collection programs. In this scheme, a state or county can receive an additional 15% incentive payment for funds collected in AFDC child support cases. The 15% comes from the federal share of the AFDC monies distributed back to the programs. One outstanding feature of this funding program has been a rapidly increasing degree of cooperation among states and counties, i.e., a "profit motive." For example, if an absent parent resides in a state other than that of the children (who are on AFDC or the Non-AFDC Child Support Enforcement program), the state having jurisdiction over the absent parent and making the collection receives 15% of the gross collection amount and 75% FFP for the effort. The state referring the case receives the share of AFDC FFP funds, and the federal government receives its portion. Therefore, the reciprocity taking place among jurisdictions is positive. The state doing the actual enforcement action can generally afford to allocate sufficient resources to maintain a successful program and also handle the referral work from other states.

The current financial system has also stimulated states to implement effective programs. While federal legislation has played an important role, states have initiated and passed many laws in support of the program. In fact, more legislation has been passed in the last 18 months in support of the child support concept than ever before in the history of the nation.

State Legislatures have recognized the social and monetary benefits of strong programs. In part, state and county participation has been engendered through the current funding mechanism.

As practitioners in the field we are concerned that the proposed restructuring of the program will undermine many of the accomplishments experienced over the first six years. While we are all concerned with reducing the federal deficits the nation is experiencing, the short-term savings of $25 million in FY 82 and $100 million in FY 83 are devastating to a program that is doing something about the root cause of the AFDC program -- Lack of Child Support. According to figures from the Office of Child Support Enforcement, over 80% of the reason for AFDC assistance is that families receive insufficient, or no child support.

As currently constituted, based upon information we have received, the restructuring proposal consists of a formula concept of funding wherein the states will operate their total programs out of collections and the Federal government will share in the profits or losses of that state operation. The Federal government would also provide incentives for states who, based on certain criteria, "improved their effectiveness and efficiency on an annual basis." The result of this proposal would be the elimination of the current 75% FFP and the 15% states now receive of AFDC collections. Also a very significant point is the fact that the Secretary of HHS can change the formula every two years as deemed appropiate.

The proposal presently consists of a two-tier approach to Federal funding. Tier I compares collections of a jurisdiction to the costs incurred. Total AFDC collections (after payments to families, refunds, etc.), less expenditures for both AFDC and Non-AFDC results in "net profit." After that, distribution of net profit is made (FMAP Split). This split varies from state to state depending on the match rate of AFDC and Medicaid. Operations will be funded using this "profit" in addition to the incentive money available from Tier II (described below).

Also, we have been told that loans will be available from the Federal Government to begin this program July 1, 1982.

Tier II is concerned with incentives to states. Incentives will be paid based upon two criteria: 1) Total AFDC collections increased during the year and, 2) Cost effectiveness improvement during the year. The first element of Tier II specifies that a 5% incentive will be given to those states showing a collections increase between that minimally expected (3-5%) and the national average of about 13%. Or, a 10% incentive will be given to those states showing a collection increase above the national average.

In the second element of Tier II, demonstrated cost effectiveness will provide for a 5% incentive to be given to those states with a cost effectiveness ratio greater than 1 to 1. Or, a 10% incentive will be given those states with a cost effectiveness ratio equal to or greater than the national average. Or, a 15% incentive will be given to those states with a cost effectiveness ratio over two to one.

Incentives will vary from year to year, depending on national averages, changing of the base year, and the Secretary of Health and Human Services' perception of needs for the program. Incentive payments are based on total AFDC collections noted in Tier I of the proposal.

Minimally, the impact upon the various states' programs would spell the demise for some, drastic curtailment in the effectiveness of others, and for a few, increased profits.

Some of the problems that we foresee with this restructuring are:

(1) The proposal provides no incentive for states and jurisdictions to perform interstate enforcement work. Therefore, it is presumed that this aspect of the Child Support Enforcement program would almost completely terminate. The results would be havens where irresponsible absent parents could avoid their child support obligations. Many of these absent parents are highly mobile and

would have little difficulty in relocating to avoid support payments. In many cases this could be accomplished simply by crossing state boundaries, even within the same city. Even with the present funding system there are problems with the interstate reciprocity. The proposal serves to exacerbate this situation.

(2) The efforts towards establishment of paternity will undoubtedly suffer under the restructuring proposals. Paternity cases often involve protracted court involvement and are generally not "economical" to work. The formula allows no latitude for the difficulty and expenses of these cases. Given the statistical data previously mentioned (17% of the nation's births are "out of wedlock"), the social and economic good provided would be critically impaired.

(3) The Non-AFDC support enforcement program would be seriously set back. While the proposed formula does consider the costs of administering this portion of the program, none of the collections or the avoided costs (by diversion from the AFDC public assistance program) are considered or rewarded. With no recognition of the positive impacts of this portion of the program, many states would be under financial constraint to retreat from this effort. The cost avoiding nature of the program would deteriorate, resulting in an escalation of the AFDC rolls. To compound this problem, the recent cutbacks in AFDC funding of the "30 and 1/3" working mothers incentive program, the 150% cap, and other measures, have made former AFDC recipients reliant on this program in the hope of getting the child support they are due. Thus, their desperation may be compounded because there may not be a helping source for the collection of child support, the obvious result being their return to the AFDC rolls!

(4) The Federal government has assumed, erroneously in our opinion, that the program will remain at the current level in spite of the restructuring proposal and, therefore, the $100 million will be saved. Numerous discussions and letters from actual practitioners in the field seriously challenge this assumption. Many states indicate they will almost be put out of business by the new funding approach. What now is a statewide enforcement program may become little more than a skeleton crew at a State office trying to assume a responsibility formerly handled by many more trained staff. The reason for this impact is that many counties will withdraw from the program when there is no longer a financial incentive to do the work. The Federal government has failed to adequately take into consideration the profit motive that the states and counties have had in the development of this program. With this profit motive eliminated, or more accurately, made very obscure, many of the jurisdictions who contract with their counties for child support enforcement will drastically cut back their efforts unless the state guarantees to hold them harmless. Most states cannot afford to do this.

Conclusion

Considering the relatvely short life of the Child Support Enforcement program (six years), much progress has been made. It seems incredible to the practitioners at the state level that a program which has returned over $6 billion at a cost of $2 billion should be the target for budget cuts. The program is making significant strides toward restoration of financial responsibility among absent parents. In 1975, this concept was highly hypothetical. Today it is becoming a reality. Over the years the states and Federal government have been in partnership in passing legislation and developing programs directed to achive this goal.

The program, both on the national and state levels, is on the threshold of astounding success. To avoid expending $100 million in one year (Fiscal Year 1983) sounds very appealing. It is our belief, however, that closer scrutiny will reveal that this is a shallow and short-sighted approach. The adage, "If it isn't broken, don't fix it," applies to this situation.

The National Council of Child Support Enforcement Administrators believes that the proposed financial restructuring of the Child Support Enforcement program should be rejected. Your favorable consideration to allow the current structure to remain in place will insure continued growth of this socially and financially responsible program. We would encourage the passage of laws which will be beneficial to the program and restoration of an ethic that children should be supported by their parents, not the government. To this end a national wage assignment law is recommended. This type of legislation, already law in a number of states, would yield over $100 million. The courts are also inundated with civil child support related matters, when the truth of the situation is that these matters could be handled in most instances very adequately through an administrative process which assures appeal to a judicial court in the case of dissatisfaction with the administrative ruling. This process nationwide would save over $200 million. This process has been incorporated by fourteen states. In summary given more resources we will deliver many times the $100 million needed.

STATEMENT OF BETTY HUMMEL, ADMINISTRATOR, CHILD SUPPORT ENFORCEMENT PROGRAM, KANSAS STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, TOPEKA, KANS.

Mrs. HUMMEL. Mr. Chairman and members of the committee, I am Betty Hummel, child support enforcement administrator for the State of Kansas. I am also here representing, as an executive board member and a member of the legislative committee, the National Uniform Reciprocal Family Support Enforcement Association. This association represents approximately 5,000 membership of local child support enforcement practitioners, including judges, State's attorneys, prosecuting attorneys, State administrators and workers. As a group we are very concerned about the proposal that has been brought forth to you to change the funding in this particular program. The program right now does run concurrent with the desire within this committee and the administration to cut budget proposals. We at the local level, recognize that when an absent parent does pay his child support he is indeed eliminating some of the dependencies that you have heard about this morning in some of the prior testimony.

When a single head-of-household mother has the capability of having this additional financial support in her household, she can then not become so dependent on some of the other programs that are in the social welfare agencies.

As local practitioners, we daily have to deal with the economic woes of these single heads of household. We have made great strides over the last 6 years to try to reduce the myth that one can shirk their financial responsibility by leaving the home and placing this additional responsibility for future years, with the one parent who is trying to maintain the household.

As local prosecutors and child support practitioners, we have to deal with these elements very realistically. The motivation in this program has already brought cuts in relief to the local taxpayer through our ability to actually make strong enforcement efforts.

We need to continue to be very strong in removing this myth that children can live without their child support moneys that they have rightful entitlement to.

Insofar as the local taxpayer is concerned, we feel that the administration has overlooked the cost avoidance aspects of the program. This past year in the State of Kansas, for instance, by removing children from public assistance rolls, we saved the State of Kansas through cost-avoidances an estimated $3 million by reducing public assistance grants and medicaid, and food stamp benefits.

There is some savings that I think continually get ignored; that as we collect the child support this helps the mother get over the peak of her financial eligibility on public assistance, which the taxpayer in the food stamp and medicaid program.

From the non-P.A. prospective, if the mother is not poverty level but borderline, and she applies for medicaid or food stamps, any child-support payments would be included in her budget for eligibility purposes which is another form of cost savings. We recognize these cost saving benefits, but it seems in many instances these benefits have been ignored by the administration.

In conclusion, we want Congress to carefully look at the proposed funding formula and understand that it is really adding to the bureaucratic entanglement; that it will reduce program momentum and actually the beneficiary of this particular budget proposal will not be the children of the State or the taxpayer . . . it will definitely be the Administration. We do not want to give a message to single heads-of-households that we are not providing services which are in the best interest of their children.

Thank you for allowing us to appear.

[The prepared statement follows:]

KANSAS

Child Support Enforcement Program

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National Reciprocal and Family Support Enforcement Association

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Statement By

Betty A. Hummel

Before The

Senate Finance Committee

Tuesday, March 16, 1982

STATE OF KANSAS
JOHN CARLIN, Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Betty A. Hummel, Administrator
Child Support Enforcement Program
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Mr. Chairman and Members of the Senate Finance Committee:

The State of Kansas, Child Support Enforcement Program is grateful for this opportunity to present our concerns and recommendations regarding the proposed fiscal year 1982 and 1983 budget cuts that affect the Child Support Enforcement Program. I am Betty Hummel, the Child Support Enforcement Administrator for the Kansas Program and immediate past president of the National Council of Child Support Enforcement Administrators. As an executive board and legislative committee member for the National Uniform Reciprocal Family Support Enforcement Association, I am here to express their endorsement of this position also.

Alternative Funding Proposal

The first topic I would like to address is the alternative funding proposal the Administration is recommending for fiscal year 1982. It is projected to produce a savings of $35 million in fiscal year 1982 and an additional savings of $145 million for fiscal year 1983. This alternative funding proposal is conceptualized by the Administration as a formula methodology which will increase the states effectiveness and efficiency.

The Administration developed the formula to meet a predetermined dollar cutback which evolved out of the assumption that this program was making too much of a profit for the state but not enough for the federal government. This standard of measurement sets forth the expectation that the federal government should have full recovery of their dollar investment. This forces me to ask two questions. Is it general practice for the federal government to invest dollars in programs with expectations of total dollar recovery? Are not the children of Kansas and other states which represent our future generation worth some type of investment?

I would also like to inform you that as of this writing, the state is still waiting for the official formula and supportive data that validates the Administration's projections and assumptions. The state has only had access to an unofficial version of the administration's new formula methodology.

Our conclusions are that the beneficiaries of the formula will be the Administration. For FY 1983, we project they will profit $1,561,887 from the program in Kansas while the state would lose $2,564,693 in revenue. The losers in the proposal are the Kansas children, who will receive several million dollars less in support monies, and the local taxpayer. Under the present funding formula, the local taxpayer has consistently been a beneficiary both at the county and state level in addition to the millions of dollars that have been collected.

The state of Kansas recognizes that this program was conceptualized and established in the mid-1970's through the persistant efforts of a very prominant member of this committee, the Honorable Senator Russell B. Long. The program was entrusted with the responsibility of reversing society's apparent acceptance that parents could shirk their financial obligations to their children by not paying their child support thus burdening the taxpayer with this responsibility.

The state has pledged to administer a quality child support enforcement program in the best interest of our children. This involves establishing and enhancing an ongoing ethic of parental responsibility through the payment of child support which thereby relieves and minimizes the need for public assistance and the burden on the taxpayer. We concur that the state has a responsibility to the taxpayer to be not only effective but efficient in operating such a program.

We forecast that if implemented, this funding formula will erode the substantial foundation laid during the past five years by this program. No matter how outstanding a particular program might be, with all the changes coming forth, states and their local political subdivisions will have to adjust present program emphasis due to the reductions in funding. The bottom line is that as funding cutbacks occur, staffing levels will be reduced, less enforcement activities will be undertaken and there will be a reduction in collections. Coupled with this will be a decrease in effectiveness because monitoring and follow-up activities will diminish, leaving America's children and local taxpayers victims of the system.

Facts about the funding formula:

1. The funding formula revolutionizes state funding methodology since it requires the program to directly fund expenditures out of its collections effective July 1, 1982. States like Kansas will have several immediate problems:
    a. Fiscal year 1983 funding allocations are presently before the state legislature with funding levels already determined;
    b. State appropriation changes such as that suggested by the new formula requires legislative approval; and

c. Local political subdivisions who have contractual service agreements with the state programs have funding commitments through the calendar year with no flexibility to adjust to a July 1, 1982 implementation deadline.

2. The Secretary of H.H.S. is suppose to have the authority to change the funding formula every two years. This manipulation of the formula will cause the program to lose credibility with local jurisdictions thus handicapping the program's ability to effectively achieve its purpose. The flaw in the Administration's thinking is they fail to recognize that the funding proposal will have a real negative impact with local jurisdictions. Without local participation in the program, the proposed savings projected by H.H.S. will not be realized now or in the future.

3. The formula criteria compares total program expenditures to AFDC collections, thus ignoring two very critical program responsibilities, the Non-AFDC collection achievements and the payments refunded to families removed from the AFDC Program because of the child support collection. By ignoring the productivity of the Non-AFDC Program, it forces the state to diminish their commitment to this element of the program. Also, the Administration has failed to recognize that recent cuts in the AFDC Program have already removed many children from the welfare system. Now, more than ever, these households need their child support monies since the AFDC payment has been eliminated. To now add to the economic woes of these families by not providing quality child support services will translate into a message to single parent households that the Administration has deserted them. It cannot be emphasized enough that the major focus of the Non-AFDC Program is to assist single parent households in the lower economic strata.

These parents find themselves in the middle of a dilemma. The court system, in most states, does not enforce support on its own, and involvement in the legal domestic system is not only costly but confusing and intimidating. Thus, in the past, many parents did not have a means of enforcement if they could not afford private counsel. Many gave up hope of ever obtaining the money rightfully entitled to their children until the Child Support Program was established. The program has been a positive alternative to what was once a hopeless situation.

4. It decreases effectiveness since the formula fails to give credit for interstate activities and discourages work on paternity cases. Both involve high immediate costs offset with long-range benefits. If a state's operational expenditures become more restrictive, states will no longer benefit by processing paternity cases and doing activities for other states thus reducing the number of children legitimized and eliminating interstate collections. This means absent parents can avoid parental and financial responsibilities by simply crossing state lines and refusing paternity acknowledgement. Escape havens once again exist.
5. Local prosecutors who do most of the program's legal activities are caught in the middle of a political dilemma along with the states. It is morally and politically sound to participate in the program because more than 50% of the court ordered child support requires enforcement activities. However, it is not sound management to become financially over committed because a funding element is difficult to administrate and financially unreliable. The formula is two tiered and will be extremely burdensome to administrate. The applied methodology on both tiers is based on four quarters which are contrary to the local political subdivisions' fiscal year. Incentive payments will be reconciliated once a year after the four quarters are determined rather than monthly which the present system allows. Thus prosecutors and states will have to become experts in collection and expenditure forecasting and will be expected to accurately predict unemployment rates, inflationary factors, and other economic conditions which are standards presently unachievable by well-known economists and the Administration.
6. The formula places the total management and financial burden on the state while still imposing extensive audit criteria with threats of penalty. Is it logical to expect the states to rejoice over losing local funding dollars, assuming the total financial and operational aspect of the program, meeting federal auditing standards under pain of penalty and turning a profit for this outside shareholder which provides little or no service?

Recommendations

We recommend that Congress recognize the momentum that is behind this program and strengthen it. Instead of focusing on a funding formula that will weaken the program, reverting back to a permissiveness which allows parents to shirk their parental responsibility, address remedies that will stiffen the penalty such as:

1. Strengthing the domestic court system by encouraging a family court system that strongly addresses domestic matters on the front end where the problem begins. The current "pay and chase" method has proven historically to be cumbersome and inefficient;
2. Enacting a national wage assignment law;
3. Developing a stronger more uniform family support law. Interstate cases are inherently difficult even with the Uniform Reciprocal Enforcement Family Support Act; and
4. Mandating the collection of judgment interest on all past due support. Several states presently charge interest and such a process should not disrupt state law or procedure but rather be consistent therein. It should apply to both public assistance and nonpublic assistance cases to avoid constitutional challenges; and
5. Reemphasizing a strong commitment to the Non-AFDC portion of the program.

In summary, we believe that Congress needs to act now to relieve the program of this proposed funding formula. The momentum of this program should not be stymied by further bureaucratic entanglement. We feel tampering with the current program by imposing the new funding formula would be undermining the development of a program which already runs concurrent to the goals of both Congress and the Administration...to reduce the federal budget. Instead Congress should provide positive reinforcement by publicly endorsing the program's efforts and enhancing the enforcement remedies.

Thank you for the opportunity to testify. We are pleased that the Committee is carefully reviewing the merits of the Child Support Enforcement Program. We are prepared to work with you so that the beneficiaries of this program will remain the children of this country and the local taxpayer.

The CHAIRMAN. I think this is a good program. I don't have any doubts about that. And, again, it has strong support on this committee. I think the changes are part of a continuing effort by the administration to figure out some way to reduce total Federal spending.

Again, it is easy to say, "Well, we don't want to change anything. If we are going to lose $1, we are opposed to it." But we must look at this program and the administration's proposals. There is a very liberal Federal payment involved.

I watch television from time to time to find what's not going on. I think a couple of weeks ago, on a Saturday, they were interviewing this poor lady in North Carolina. They asked her all the obvious questions. She had lost her job, and it was a tragic case. She had two children, and the one question they didn't ask her was, "What about child support?" The media doesn't understand, I guess, that there is an obligation to pay on the part of that father who has taken off. They think the Government ought to do everything. There are some people who come before this committee thinking the Government ought to do everything.

That's why some of us feel that this is a good program. We are not going to do anything to jeopardize it; but, again, that doesn't mean that we can't look at some way to save a few dollars on the Federal side. That's what our obligation is.

Yes?

Mr. ABBOTT. Mr. Chairman, if you would permit, I would like to introduce some statements for the record that have been prepared relative to the members of this committee and the States they represent, in terms of how they feel about the formula.

The CHAIRMAN. One for each member?

Mr. ABBOTT. Yes, sir.

The CHAIRMAN. Well, maybe we ought to just give those to the members. Let's not reprint all of that. That costs money, too. But we will see that the members receive copies. Our printing bill is $1 million a year, and we are in the process of trying to streamline that, too; like charging lobbyists for reports, and things of that kind that the taxpayers have been paying for. I don't consider you lobbyists—you are public servants. [Laughter.]

Well, thank you very much, and we appreciate your statement. I know that Senator Long has a fatherly interest in this program, and he does believe in support for his program.

Thank you.

Mr. ABBOTT. Thank you.

The CHAIRMAN. Our final witnesses this morning are Marion Smith and Barbara Blum. Mr. Smith is a member of the National Governmental Affairs Committee, Association for Retarded Citizens. Barbara is the Chairperson, National Council of State Public Welfare Administration and Commissioner of the New York State Department of Social Services, on behalf of the National Council of State Public Welfare Administration.

STATEMENT OF MARION P. SMITH, MEMBER OF THE NATIONAL GOVERNMENTAL AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS, WASHINGTON, D.C.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Chairman, I will present testimony for your record on behalf of 9 disability organizations which represent 4,600 chapters and over 2 million members around the country.

Mr. Chairman, our testimony is based upon the premise that the provision of a basic core of services to America's disabled citizens is a legitimate responsibility of the Federal Government. However, Mr. Chairman, we recognize our responsibility as citizens to help you in your job here, working on the finances of our country.

Therefore, last year, at your invitation, after I testified to this committee I submitted to you a letter dated April 10 in which we forwarded to you 15 recommendations for cost-effective alternatives in the delivery of human services for disabled people in our country, aimed at reduction of cost and also offering some priorities for these cost-effective measures.

We observed that in the intervening year, sir, three of those recommendations have been adopted. And, from listening to your earlier comments, Senator, we are prepared to update that document and offer it to you for additional consideration.

Just a few key points of summary from our written testimony:

We strongly oppose the administration's proposal for an additional cut of 3 percent in the Federal share for optional medicaid services. Many States are eliminating a number of these services. It is unlikely that State medicaid programs will be able to absorb these cuts without further severe reductions in services.

My second summary point: We are concerned, Senator about the proposed medicaid changes which are aimed at shifting the cost of services to recipients and their families. For example, the provision to require relatives to supplement medicaid payments for persons in long-term care facilities failed to recognize, in my view, the extra effort and expense associated with being the parent of a disabled child. I know. My wife and I are parents of a severely disabled Downs Syndrome child, and the costs are extremely significant for such parents.

The third summary point: We strongly support the earlier testimony—and I testified last year—concerning section 933 of the Omnibus Budget Reconciliation Act of 1980, Public Law 96-499. Senator, this is a cost-effective measure. Permitting services to qualify under medicare in outpatient rehabilitation facilities is a cost-savings measure. It would not be in the economic interest of the country to repeal section 933.

Three of the administration's proposals for the SSI program are particularly offensive to us: Changing the definition of disability from a 12- to a 24-month prognosis; giving added emphasis to medical factors in determining whether an applicant for SSI is disabled; and eliminating the initial $20 disregard of income for all new recipients. That last item particularly works against the economic motivation of the retarded person to do useful work—retarded or otherwise disabled.

We vehemently oppose further cuts in the social service program because experience with the new block grant shows that disabled people and their organizations often are not equipped to compete for scarce funds and services at the State and local level.

Some examples from the State of Florida—I am from Clearwater: $2.9 million was cut last year from title XX funding. The State made up $1.9 million, leaving $1 million to be further reduced. As one example of the damage, this left one social worker to deal with 113 clients of the Florida Health and Rehabilitative Services organization. Habilitation plans are now reviewed once every 2 years, rendering them virtually useless. Therefore, sir, the cuts created an untenable situation.

We appreciate the opportunity to testify, and we will be willing to follow up later, as I indicated.

The CHAIRMAN. Thank you.

[The prepared statement follows:]

TESTIMONY

on

FISCAL YEAR 1983 PROPOSED BUDGET

for

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Respectfully Submitted

to

THE COMMITTEE ON FINANCE

U.S. SENATE

on behalf of:

American Coalition of Citizens with Disabilities
American Foundation for the Blind
Association for Retarded Citizens
Epilepsy Foundation of America
National Easter Seal Society
National Mental Health Association
National Multiple Sclerosis Society
National Society for Autistic Children
United Cerebral Palsy Associations, Inc.

Witness:

Mr. Marion P. Smith
Member, Governmental Affairs Committee
Association for Retarded Citizens

Tuesday, March 16, 1982

> We believe it is time to relieve the poor, disabled and elderly of their role as victims in the fight for national security and a balanced budget. How can they continue to care that their country is safe if they are not themselves safe from their own country?

Mr. Chairman and distinguished members of the Finance Committee, it was exactly one year ago (March 26, 1981) that I appeared before you regarding the Administration's fiscal year 1982 budget proposals for the Department of Health and Human Services. At that time, I expressed concerns, on behalf of the nine organizations listed on the front page of our testimony, regarding the President's Program for Economic Recovery which called for a wholesale and indiscriminate consolidation of federal social programs, along with substantial funding reductions. Our organizations raised questions regarding block grants and described what we feared would be the outcome of such an approach to the delivery of basic human services.

The questions have now been answered and the outcome confirmed.

- In Columbus, Ohio, as a result of a $180,000 Title XX program reduction in their Handicapped Adult Services Program, 110 disabled adults have been terminated from service. These adults now are isolated in their residential setting with absolutely no daily or special day services.
- A developmental center in Indiana serving developmentally disabled children and adults has discontinued its summer camp which it has run for twelve years. The infant and toddler screening program, which screens for developmental lags in approximately 500 children each year is also being discontinued, as is the adult vacation and recreation program for 75 adults. Center staffing has been reduced and 11 percent of the clients have been terminated.
- A health clinic sprouted a crop of new signs this winter: "No more dental care. No eyeglasses. No free medicines. No lab work. No transportation. We can no longer pay for inpatient and outpatient care at Children's Hospital."

- In Erie, Pennsylvania, as a result of a Title XX cut, the United Cerebral Palsy Adult Day Care Program serving 36 persons with disabilities was closed.

- A nurse worries about a little girl whose Medicaid no longer pays for the drugs necessary to control her epileptic seizures.

- In Clarksville, Arkansas, a three year old retarded boy named Allen waits to leave the nursing home where he's lived since he was seven months old. His mother lives 200 miles away in West Helena. She has seen him once in two years.

  Recently the nursing home staff told his mother that Allen was ready to come home if he could attend the Phillips County School for Exceptional Children. But there is no room at the school because its budget has been reduced.

  It costs taxpayers $19,080 a year to help Allen in the nursing home. It would cost $3,500 a year for him to attend the school.

- On October 1, 1981, the State of Delaware ended its Title XX funding to the Community Legal Aid Society, Inc. (CLASI). The state had provided CLASI with approximately $67,000 per year since 1974.

- The mental retardation/developmentally disabled service providers (MR/DD) of Indiana are being surveyed to learn what, if anything, has happened to them as a result of last year's budget reductions. To date 25 provider agencies (almost 40 percent of all MR/DD providers) have responded. They report that without the budget reductions they would have been able to serve an additional 672 clients during this fiscal year.

  Under the current budget levels they will deny services to an additional 433 clients during fiscal year 1983. Thus, the total number of clients denied services over the two year period will equal 1,105.

Examples such as the above are beginning to fill our country's newspapers and flood the offices of our national human services organizations. Currently several of our organizations are conducting surveys to gather precise details on the impacts of the block grants and budget cuts on programs serving disabled persons and on the lives of disabled individuals and their families. One such survey initiated by the United Cerebral Palsy Associations, Inc., relative to Title XX Social Services and Maternal and Child Health is attached (Attachment I).

Our testimony is based on one premise: that the provision of a basic core of services to America's disabled citizens is a legitimate responsibility of the federal government.

Our organizations support efforts to eliminate fraud and abuse, to streamline programs, and to avoid unnecessary, time consuming requirements and duplication. We made this clear in our March 26, 1981 testimony and in our follow-up letter to Senator Dole in which we prioritized programs for disabled persons and offered suggestions for program modification or consolidation. However, rather than targeting programs reputed to be wasteful and abusive, this Administration has sought and continues to seek across-the-board reductions, harming the guilty and the innocent alike.

President Reagan has called for a new spirit of voluntarism within the private sector to help offset the budget reductions. He believes that private giving can "fill the gaps" left by the severe program terminations and budget cuts he proposes. All evidence is to the contrary. A study completed last fall by the Urban Institute for Independent Sector states that the Reagan economic program will cause a $27.272 billion loss of funding to health, welfare and arts organizations by 1984. The report estimates that an increase of 26 percent in private giving would be necessary by 1982 to fill the gap, and suggests that such an increase is not likely. In fact, an analysis of the new tax law indicates that the country's private charities may lose as much as $18 billion over the next four years because President Reagan's tax cuts give the wealthy less incentive to give.

Leaders of foundations, churches and businesses agree that private giving will not keep pace with the reductions in federal programs, particularly during downturns in the economy. According to these leaders the people who give - usually people who aren't wealthy and often people living on a fixed income - are only giving a portion, sometimes only half, of what they used to give (e.g. $5 instead of $10). They point out that when the income of people goes down, so does everything else. In addition, many businesses are being forced to lay off large numbers of employees and will fall short of giving what they gave in 1981.

Faced with the President's fiscal year 1983 budget our organizations are becoming cynical. We believe disabled persons have a right to live in the community, to be educated, to receive basic health care, and to work. We believe the federal government has an inherent responsibility to ensure these rights through the provision of basic human services. Yet this Administration continues to endorse a philosophy which is denying disabled people the opportunity to exercise their rights and become contributing members of our society.

The disabled and elderly are the hardest hit by the budget cuts. We are here asking your help in achieving equity and fairness in the distribution of our federal tax dollars. Our message is simple: if belt-tightening is necessary, it should not be done indiscriminately nor should it be limited to domestic programs only.

No responsible American wants to see an inadequate defense. But just as domestic programs can be guilty of waste and abuse, so too can defense programs. Yet, neither the fiscal year 1982 budget nor the budget proposed for fiscal year 1983 -- both of which include hefty increases in defense spending -- attack inefficiencies and waste in defense expenses, not even those expenses having no bearing on our national security. Our organizations are concerned about the deficit. However, we urge Congress to examine the entire federal budget in its quest for solutions to our economic problems. Included in this examination should be a close scrutiny of the defense budget as well as proposals to adjust some of the tax cuts passed last year.

MEDICAID

Our organizations strongly oppose the Administration's proposal for an additional cut of three percent in the federal share for all optional Medicaid services. Last years' reduction in federal reimbursement, coupled with the states' economic problems, make it unlikely that any state Medicaid program will be able to absorb an additional three percent cut without further severe reductions in services offered. Already states are eliminating many of their optional services, and thousands of persons have been dropped from the Medicaid roles.

Included among optional services are prescription drugs, home health care, dental services, speech, physical and occupational therapies, and prosthetic devices such as braces, crutches and wheelchairs. The Intermediate Care Facilities for the Mentally Retarded (ICF/MR) program and the new waivered services for home and community-based services for persons at risk of institutionalization are also optional. Reductions or elimination of these services is short-sighted. While the federal government might show an immediate "savings" in its budget, there will be no long-term "real" cost savings. The reduction in preventive and primary care services will produce greater health problems and higher costs later on. Without the optional services funded through Medicaid many disabled people will become more severely disabled. Many children will lead lives of almost total dependency - unnecessarily.

Further cutbacks in the Medicaid program would play a primary role in the process of reinstitutionalizing many disabled persons. The Medicaid program, through the Intermediate Care Facilities for the Mental Retarded program, finances state-operated institutions and small community residencies for mentally retarded and certain other developmentally disabled persons. While the entire ICF/MR program is optional as well as the new in-home and community-based care provisions, it is likely that states, facing the need to reduce services, will choose to retain the large institutional programs due to the large mortgages, bond debts, and increased capital expenditures required to meet the life safety code for Medicaid certification. This would mean that community-based services would be primary targets for reductions or terminations.

We believe it is in the public interest to develop and maintain a system of services and living arrangements, within our communities, which permanently disabled people may tap as needed to help them learn and maintain the skills to be as independent as possible.

This type of community-based system is in the public interest because it will save tax dollars. Most disabled persons, if properly housed and served in the community, will function more independently than their counterparts in institutions and will often become employed, thereby contributing tax dollars and reducing their reliance on federal and state support.

Organizations that represent disabled people have made this same statement for years. We have presented data to Congress and the Administration showing that what we say is true. Yet, the federal government continues to alter programs and reduce funding levels in a manner which promotes institutionalization.

Our organizations have questions regarding certain other of the Medicaid proposals, for example, the proposal to require relatives to supplement Medicaid payments for persons in long-term care facilities. Would there be a distinction made between a parent's fiscal responsibility for a child in a long-term care facility and a child's fiscal responsibility for a parent? The number of years that an elderly parent will stay in a nursing home is generally fewer than the number of years a disabled child or young adult might stay in the same facility. If no distinction is made between the two situations the parents of disabled sons and daughters would be placed in a position of almost lifetime fiscal responsibility. This is not the case for parents of non-disabled children. When a non-disabled child reaches the age of maturity, parents are no longer legally responsible. Any provision to require relations to supplement Medicaid payments for persons in long-term care facilities must recognize the extra effort (and extra cost) associated with being the parent of a disabled child.

We are seriously concerned about this and other proposed Medicaid changes contained in the President's budget which are aimed at shifting the costs of services to recipients and their families. We've begun to feel as one director of a self-help corporation did when he responded, "If there is a safety net, it is buried below the ground."

Our organizations believe that efforts to whittle away at basic health services in order to "save" federal dollars has reached a point of diminishing returns. The negative consequences of the Medicaid proposals on the lives of low-income disabled persons and their families will far outweigh any savings benefits they might have in the short run. It does not appear that the fiscal year 1983 budget proposals for Medicaid are the product of thoughtful consideration about their immediate and long-term impact on the poor, elderly and disabled who have no place else to turn to obtain needed services. They can no longer rely on the charity of physicians and hospitals. Recognizing that Medicaid services are being severely reduced, physicians point out that they cannot be expected to care for patients dropped from federal programs. With the tremendous increase in the cost of health care they simply cannot afford to do so. As one doctor stated, "society will have to pay for these children" when they develop chronic health problems.

We also have serious reservations about the President's proposal to federalize the Medicaid program. Several major questions come to mind: (1) How will the federal government standardize eligibility? (2) How will the federal government change the program to equalize benefits among the fifty states? (3) What happens to optional services such as the Intermediate Care Facilities for the Mentally Retarded (ICF/MR)? The answers to such questions would determine the fate of thousands of disabled individuals currently depending on Medicaid for necessary health and health-related services.

MEDICARE

In our testimony today, we would like to address only one issue relative to the Medicare program.

Late in 1980, Congress passed and President Carter signed the Reconciliation Act of 1980, P.L. 96-499. Section 933 of the Act recognizes outpatient rehabilitation facilities as providers under Medicare. The effect of this provision would be to make all of the services which these facilities provide, including physical therapy, occupational therapy, speech pathology services, and respiratory therapy, reimbursable under Part B of Medicare. No new benefits would be added by this provision, but rather, the setting in which these services are provided would simply be expanded to include freestanding outpatient rehabilitation facilities.

This provision was to have been effective on July 1, 1981. However, repeated attempts by the Administration to rescind it, along with other Medicare provisions, and long delays at the Health Care Financing Administration (HCFA) in promulgating the required regulations have prevented implementation of this Medicare amendment.

Last spring, the budget proposed by President Reagan called for the repeal of Section 933. Fortunately, Congress acted to retain this provision in the final version of the Omnibus Reconciliation Act of 1981. Despite Congressional support of this provision in both 1980 and 1981, the Reagan Administration has again proposed the repeal of Section 933 in its budget for fiscal year 1983. We are adamantly opposed to the repeal of this provision and consider such a proposal proof that the Administration fails to recognize the need for less costly alternatives to hospital care.

Since the beginning of the Medicare program, all of these services have been covered under Part B when provided by hospitals, either on an inpatient or an outpatient basis. However, freestanding comprehensive outpatient rehabilitation facilities could only receive Part B reimbursement for physical and speech therapy services. The policy promoted the use of hospital-based services, despite the fact that the services provided by freestanding centers are less costly and frequently more accessible than those provided by hospitals.

The provision in question was first proposed in the late 1960's. Since then, it has been included in legislation which was approved by one House, but not the other. In 1978, for example, it passed the House almost unanimously as part of H.R. 13097, the Medicare Amendments of 1978, but died in the Senate because of the lateness of House passage. Enactment by the 96th Congress concluded a ten-year effort by various national organizations, most notable the National Easter Seal Society, the National Association of Rehabilitation Facilities, the American Occupational Therapy Association, and the American Association for Respiratory Therapy. Furthermore, the language of the provision was worked out over a considerable length of time with a large number of people in the rehabilitation community to insure that the covered services were sufficiently defined and subject to adequate quality control measures.

In an effort to bring about the promulgation of long-overdue regulations needed to provide Medicare services in a comprehensive outpatient rehabilitation setting, a lawsuit has been filed against Secretary of Health and Human Services Richard Schweiker and Health Care Financing Administrator Carolyne Davis. Plaintiffs in the suit include the National Easter Seal Society, the National Association of Rehabilitation Facilities, the American Association for Respiratory Therapy, three individual beneficiaries, and four rehabilitation centers. These organizations and individuals believe that the HHS and HCFA have failed to carry out their duty to implement legislation which would authorize freestanding rehabilitation facilities as Part B Medicare providers. The lawsuit also contends that any provider applying for reimbursement of services rendered under the provision is entitled to payment. As the services provided by comprehensive outpatient facilities are already available to Part B beneficiaries in hospital settings, the promulgation of regulations would merely allow greater flexibility in the selection of the most appropriate site of care. The delay in implementation of the needed regulations and the resulting inability of comprehensive outpatient rehabilitation facilities to function as providers under Medicare is causing harm to beneficiaries, providers, and the Medicare program. Beneficiaries are required to seek comprehensive rehabilitation services from hospitals, regardless of their individual needs and preferences. Providers are being forced to choose among rendering services on the chance that they will receive reimbursement under Medicare when the regulations are finally implemented, refusing to render services without payment from the client, or providing services on a totally charitable basis. Lastly, the Medicare Trust Fund continues to be unnecessarily burdened by high acute care charges which, if provided on an outpatient basis, would surely be less costly.

When this Medicare amendment is implemented, many of your constituents will have greater access to the medical services which they require. In addition, the cost-effectiveness inherent in this provision will contribute to a more responsible utilization of Medicare funds.

We, therefore, urge you to oppose any efforts to repeal this Medicare provision and ask that you act to expedite the implementation of the regulations needed to put this legislation in place.

CHILD WELFARE, FOSTER CARE, ADOPTION ASSISTANCE

Our organizations are adamantly opposed to the Administration's proposed Child Welfare block grant and its reduced funding level, i.e. $380 million for fiscal year 1983. This is less than current year expenditures for foster care alone. If enacted, the Child Welfare block grant would mean an end to P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980.

This law was enacted with strong bipartisan support in Congress. We believe that this support continues and urge the continuation of the child welfare, foster care and adoption assistance programs as detailed in P.L. 96-272. This legislation, like other legislation targeted for block grants by the Administration, was enacted because of states' failure to accomplish needed reforms in their foster care systems. This failure was recognized as a national scandal which required federal intervention. A retreat from federal responsibility in this area will wipe out the benefits of the years of thoughtful consideration which went into P.L. 96-272 and result in new scandals involving abused and neglected children.

Like Section 933 of the Reconciliation Act of 1980 (described previously under "Medicare"), the Administration has delayed effective implementation of P.L. 96-272 and has not yet published implementing regulations. We believe the Department of Health and Human Services is not carrying out its responsibilities under the law and are persisting in administering the program as if it were a block grant. The House Ways and Means Subcommittee on Public Assistance and Unemployment Compensation has requested the General Accounting Office to undertake a study regarding the implementation of P.L. 96-272. We strongly support such a study and urge the endorsement of the Finance Committee. We also urge you to request that the Department of Health and Human Services expedite the publication of the implementing regulations.

WOMEN, INFANTS, AND CHILDREN (WIC)

We oppose the President's proposal to fold the supplemental program for Women, Infants, and Children (WIC) into the Maternal and Child Health block grant. We oppose the 35 percent cut in funding for WIC which is contained in the President's fiscal year 1983 budget.

The proposed 35 percent cut in the WIC program is another example of this Administration's across-the-board cuts without regard to the effectiveness of the particular program. With WIC, for example, medical research at major universities and at a number of state health departments has found WIC to be extraordinarily effective. A study conducted at the Harvard School of Public Health found that WIC caused a marked reduction in the incidence of low-birth-weight infants. Low birth weight is the eighth leading cause of death among children in the United States. Low birth weight is also associated with increased incidence of disabilities such as blindness, deafness, and mental retardation. The Harvard study found that, because of the reduced incidence of low-birth-weight infants needing extended hospitalization after birth, each dollar spent in the prenatal component of WIC actually averts $3 in hospital costs. The General Accounting Office (GAO) estimates that for each case of mental retardation prevented the total gain to society is almost $1 million.

The American Public Health Association (APHA), and public health workers are worried about the President's proposed budget cuts in health programs like the WIC nutrition program. Health experts have warned of the long-term health consequences of budget reductions in programs providing nutrition for mothers and infants and disease prevention. Stanley Matek, president of the APHA, stated that "The Administration has launched an assault on key health programs which ..... is without good justification..."

We urge you to retain the WIC program as it is in order to target federal resources in the most effective manner. We also seek your support for funding at least equal to the fiscal year 1982 level, i.e. $935 million.

SUPPLEMENTAL SECURITY INCOME

The major changes proposed for the Supplemental Security Income (SSI) program in the President's fiscal year 1983 budget represent yet another effort to tighten up on the eligibility of disabled persons for disability benefits in a program which is already one of the toughest in the nation. Our organizations find the following three proposals particularly objectionable:

1. changing the definition of disability to to require a 24-month, rather than a 12-month prognosis (estimated savings of $45 million in fiscal year 1983);
2. giving added emphasis to medical factors in determining whether an applicant for SSI benefits is disabled (estimated savings of $75 million in fiscal year 1983); and

3. eliminating the initial $20 disregard of income for all new recipients coming on the rolls after January 1, 1983 (estimated savings of $15 million in fiscal year 1983).

The Department of Health and Human Services has estimated that these three proposals will affect 35,000, 80,000 and 300,000 individuals respectively. Given the Administration's current performance relative to the Continuing Disability Investigations called for in the Social Security Disability Admendments of 1980, we believe that enactment of any of the above proposals will only result in the denial of SSI benefits to many additional severely disabled persons with a genuine need for support. Attachment II summarizes our concerns regarding the Administration's current approach to disability review and eligibility and our recommendations. We urge the Committee through its Subcommittee on Social Security and Income Maintenance to conduct Congressional hearings, including field hearings, as soon as possible in order to address the full array of issues in the disability review process.

The disabled people in our country are not a strong lobbying force. Many severely disabled persons do not vote. Public acceptance of disabled people is far from ideal, and knowledge regarding the potential of disabled persons is lacking. Consequently, programs and benefits for disabled people at all levels of government are often the first to be reduced or terminated when dollars are scarce. We ask that you carefully assess the potential impact of each of the SSI proposals contained in the President's fiscal year 1983 budget. We also urge your immediate opposition to the three proposals cited above.

In addition, we would like to express to the Committee our deep concern regarding the Department of Health and Human Services implementation of the modified rehabilitation program for SSI and Social Security Disability Insurance (SSDI) recipients. It is our opinion that if the October 14, 1981, proposed rules are finalized they will result in a program that is either 1) a cumbersome, wasteful effort on the part of both the Social Security

Administration and state rehabilitation agencies or 2) a total elimination of the program from the effects of 1) above or by states avoiding the program altogether. The fact that theproposed rules do not provide for an advance payment mechanism as is provided in the law is a major problem. We ask your support and help in securing regulations which allow for advance payments and consequently a meaningful, workable rehabilitation program.

SOCIAL SERVICES

We strongly oppose any further cuts in the Social Services program. Experience with the new block grant and its reduced funding level has demonstrated that disabled people and their organizations often are not equipped to compete for scarce funds and services at the state and local levels. Already, programs and services of all types have been severely reduced or terminated due to the lack of social services dollars.

Of all the federal programs providing direct benefits to handicapped persons, it appears that Title XX received the largest reduction last year. This is extremely unfortunate since the philosophy of the social services program is the most compatible with the developmental model of services, i.e., services are flexible in type, non-medical in nature and can be individualized according to the client's needs.

The typical financial support of community living arrangements for disabled persons is a combination of Supplemental Security Income (SSI), Housing and Urban Development (HUD) Section 8 Rent subsidies and social services dollars. Many disabled persons are currently without adequate services. Their day care, work activity, sheltered workshop, adult habilitative, personal assistance, transportation and/or other services, formerly funded through Title XX, are no longer available. For many disabled persons the adequate funding of social services becomes a critical factor if community living is to become or remain a viable option.

Our testimony is meant to express a deep and serious concern about this Administration's policies toward the provision of human services. We believe that there are national problems for which there must be a national responsibility. The continuing erosion of life support systems which impact upon many persons with severe disabilities is endangering the physical and mental well-being of this significant population in our country. We sincerely request your assistance in avoiding any further retreat from the federal responsibility for the provision of basic services and benefits necessary to the safety, well-being and development of our country's disabled citizenry.

ATTACHMENT I

Word from Washington

ANALYSIS

Volume Eleven
Number Two

In Depth Resource Material
Prepared for Affiliates Of
United Cerebral Palsy Associations, Inc.

UCPA AFFILIATES REPORT TITLE XX SOCIAL SERVICES AND MATERNAL AND CHILD HEALTH BUDGET REDUCTIONS

This paper has been prepared at the
request of Representative John D. Dingell,
Chairman, House Committee on Energy and Commerce

by

E. Clarke Ross, D.P.A., Director and
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UCPA Governmental Activities Office

February, 1982

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DOCUMENT'S PURPOSE

This paper has been developed in response to a January 22, 1982 letter from Representative John D. Dingell (MI), Chairman, House Committee on Energy and Commerce. The Committee is gathering information "on the effects of the Reagan budget cuts on the programs under our jurisdiction" in preparation of the report they must file to the House Budget Committee.

In his letter to UCPA, Chairman Dingell stated that "I am writing to you because you and your associates were so helpful to the Committee last year when we were trying to understand the effects of each and every program cut and restructuring. During the next two weeks I hope you will be able to provide the Committee staff with updated information. What effect have the program and budget cuts had on services and people? What effect would further reductions have on programs and people? Are there any special cases, histories, or events that illustrate clearly how the budget cuts are being felt?"

THE F.Y. 1982-1983 FEDERAL BUDGET

In terms of the major federal programs of highest priority interest to UCPA, most of these programs were protected by the Congress in fiscal year 1982.

The Administration had proposed the block granting of P.L. 94-142, the "Education for All Handicapped Children Act," and had recommended funding reductions of roughly 30% from the 1981 level. By P.L. 97-35, the Budget Reconciliation Act, Congress extended P.L. 94-142 for several years as a categorical program. And by P.L. 97-92, the F.Y. 1982 Continuing Resolution, P.L. 94-142 appropriations were actually increased over 1981 for 1982. Of course the Administration has proposed a substantial rescission in these 1982 levels but Congress has not yet accepted this proposal.

Likewise, in P.L. 97-35 the Congress rejected the Administration's block grant proposals regarding state grant programs of Vocational Rehabilitation, Independent Living, and Developmental Disabilities. And P.L. 97-92 increased the 1982 VR funding level and held constant the IL and DD levels. Congress will have to once again reinforce these decisions as the Administration seeks 1982 rescissions.

The Administration also sought an arbitrary "cap" or ceiling on Medicaid expenditures in FY 1982. Again, the Congress through P.L. 97-35 retained the entitlement feature of Medicaid, rejected the cap proposal, and enacted higher state matching rates. Though matching rates were increased, because of the efforts of House Subcommittee on Health and the Environment Chairman Henry A. Waxman (CA) and Mr. Dingell, P.L. 97-35 also contained a new "waiver" provision program allowing noninstitutional community-based services under Medicaid at state option. As of this date, nine states have submitted waiver requests and two states have received application approval.

So five major programs of UCPA interest--P.L. 94-142 Education, $931 million; VR, $863 million; IL, $17.280 million; DD, $60 million; and Medicaid, $17.2 billion--were largely protected in FY 1982 (unless last minute rescission decisions are made).

However, two service areas of UCPA priority did not survive in as strong a condition. The Congress rejected the Administration's proposals to block grant both the Title XX Social Services and Maternal and Child Health services programs but major revisions were made in both programs. Regarding Title XX, state matching requirements were eliminated and the services, day care set aside, training, and administration functions were consolidated in what is now referred to as the Social Services mini-block grant. Likewise, seven previous categorical programs, including Crippled Children's Services, Genetic Diseases Program, and SSI Disabled Children's Program were consolidated into a new MCH block grant program. So the immediate focus of UCPA budget reduction concern in the human services areas (keeping income assistance and research areas separate) is with Title XX and MCH. The financial condition of these two programs follow:

Program	FY 1981	FY 1982	President's Proposed FY 1983 Budget
Title XX Social Services	$2.9 billion	$2.4 billion	$1.974 billion
Maternal and Child Health Block Grant	$447.6 million	$347.5 million	$1.000 billion
a) Women, Infant, and Children (WIC) nutrition program	$927 million	$934.1 million	0 to be consolidated with MCH
b) MCH-WIC totals	$1.375 billion	$1.282 billion	$1.000 billion

UCPA AFFILIATE APPROACH

In fiscal year 1980, UCPA's 250 affiliates had a combined operating income of $109.758 million, of which $70.457 million was derived from state and local government grants and contracts. UCPA does not operate a centralized and computerized affiliate data gathering system so financial records are frequently outdated. Records of the UCPA Washington office documented 62 affiliates receiving Title XX, CCS, or MCH funding. In response to Representative Dingell's request, a telephone survey of these 62 affiliates was developed by Merna Williamson, Research Assistant, UCPA Governmental Activities Office.

Of the 62 affiliates, 3 no longer operate any of these three funded programs and one affiliate was unreachable despite several attempts. In two other affiliates, the executive directors were not available and no one else in the affiliate could provide the necessary information. Thus this report includes 56 affiliates and 59 funded programs as several affiliates operate programs funded by more than one of these three programs.

TITLE XX AND MCH BUDGET IMPACT

Ms. Williamson's telephone survey revealed the following results:

- Twenty affiliate programs (34% of the survey) experienced program reductions; of these, 18 were Title XX reductions, 1 was CCS, and 1 was MCH.
- These 20 programs experienced Title XX, MCH, and CCS dollar reductions of at least $658,131. Roughly $127,000 of these reductions have been replaced with other public and private funding.
- Thirty-nine affiliate programs (66% of the survey), including 34 Title XX programs and 5 CCS programs have experienced no program reductions. However, many of these affiliates are expecting reductions by the end of their state's fiscal year and few of these affiliates are able to serve the needs of persons with disabilities as they would like even with present funding. Though programs have not received actual dollar reductions, because of inflation there have been real dollar reductions.
- Program reductions range from 2% in Pittsburgh in their Handicapped Adult Recreation and Social Program and in Utah in their Handicapped Summer Camping Program to 50% in Cedar Rapids where, as a result, their Handicapped Adult Day Care Program was terminated. Lexington, KY UCPA also experienced a 50% cutback which has resulted in severe curtailment of their training of parents and paraprofessionals in the care of their handicapped children.
- In Columbus, OH, as a result of a $180,000 Title XX program reduction in their Handicapped Adult Services Program, 110 disabled adults have been terminated from service. These adults now are isolated in their residential setting with absolutely no daily or special day services.
- In Erie, Pennsylvania, as a result of a Title XX cut, the UCP Adult Day Care Program serving 36 persons with disabilities was closed.
- In Illinois, work by the Human Services Override Coalition, of which UCP of Illinois is an active member, convinced the Governor's office to restore $2.4 million in Title XX program reductions. In April 1981, Governor Thompson proposed a four year program, involving 25% annual cuts, to phase-out all Title XX contracts involving donated funds. These programs will now stay operational at least through FY 1983.
- In Maine, the state's administration has declared their intent not to reduce current human services in spite of substantial reductions.
- In San Antonio, TX, where UCPA has been able to document cost differentials of $2,400 per month institutional costs and $500 per month community placement costs, UCPA's independent living program will receive a Title XX increase.

- For the 20 affiliate programs being reduced, most are reducing administrative costs, attempting new private fund raising initiatives which have not yet been successful, and increasing staff-client ratios while reducing the level of client services.

OTHER BUDGET OBSERVATIONS

- Though the Developmental Disabilities federal budget has technically only received a 4% reduction, as specified in P.L. 97-92, state DD programs are being terminated. For example, in Pennsylvania, the DD council funded in FY 1981 13 DD-CLA (Developmental Disabilities-Community Living Arrangements) programs. In FY 1982 only 3 of these independent living programs are operating and they will be terminated at the end of this fiscal year. The DD Council's expectation that these 13 programs would be permanently financed by the state was dissolved when Pennsylvania received word of the P.L. 97-35 federal reductions. Some of these program participants are now being reinstitutionalized.
- Many affiliates reported substantial reductions in CETA (Comprehensive Employment and Training Act) personnel though this was not an area of survey questioning.

SURVEY RESULTS

Specific program information listed by affiliate follows:

TELEPHONE SURVEY OF AFFILIATES RECEIVING TITLE XX, CCS OR MCH FUNDS

by Merna Williamson--February 17, 1982

STATE/AFFILIATE	Program	Cutbacks		Cut Amount	Cut Date	Services Affected	% of Budget		Cutbacks Have Been Restored by Funding Sources
		Yes	No				Before	After	
ALABAMA									
Gadsden	XX		X						
Huntsville	CCS		X						
Sheffield	CCS		X						
Birmingham	CCS		X						
"	XX	X					45%		MH Dept. made up cut
Anniston	CCS	X		$3,000		Crippled Children's	9%	6%	No
"	XX		X						
ARIZONA									
Phoenix	XX	X		$26,000		Transp., DD Therapy, Group-Home Training, All services. This prgm cut 25%	22%	16%	Some state funds
CALIFORNIA									
San Diego	XX		X						
CONNECTICUT									
Hartford	XX		X						
FLORIDA (big cuts expected)									
Orlando	XX		X				5%		
Panama City	XX		X						
Lakeland	XX		X				75%		
Miami	XX		X				75%		
Ft. Lauderdale	XX		X				30%		
Tallahassee	XX		X	--7½% increase--					
GEORGIA									
Rome	XX	X					25%	25%	No
Macon	XX	X		$500	1/1/82	Day care for disabled infants, children & adults.	25%	25%	No, Cut services
ILLINOIS									
Decatur	XX	X			7/1/81	Family support-Advocacy	40%		All funds restored
Joliet	XX	X			"	" " "			" " "

STATE/AFFILIATE	Program	Cutbacks		Cut Amount	Cut Date	Services Affected	% of Budget		Restoration
		Yes	No				Before	After	
IOWA									
Cedar Rapids	XX	X		$50,000	7/1/81	Disabled Adult Day Care	50%	0	No--working on it.
KANSAS									
Wichita	XX		X						
KENTUCKY									
Louisville	MCH	X		$27,000	7/1/81	Early childhood intervention--Infant development	14%	8½%	Special local grants
Lexington	XX	X		$100,000	7/1/81	Paraprofession & parent training to care for handicapped children	100%	50%	Local grants & endowments
MAINE									
Augusta	XX		X				10%		
Bangor	XX		X				20%		
"	CCS		X						
MARYLAND									
Baltimore	XX		X						
MINNESOTA									
Minneapolis	XX		X				8%		
MISSOURI									
St. Joseph	XX		X						
NEW YORK									
New York State (NY City)	XX		X				Small%		
Albany	XX		X				"		
Geneva	CCS		X			Pre-school	100%		
Niagara Falls	XX		X			Handicapped Adult Day			
Jamaica	XX		X						
Utica	XX		X						
Purchase	XX		X						
Buffalo	XX		X						

STATE/AFFILIATE	Pro-gram	Cutbacks		Cut Amount	Cut Date	Services Affected	% of Budget		Restoration
		Yes	No				Before	After	
NORTH CAROLINA									
Raleigh	XX	X		$30,000	7/1/81	Day Care	27%	23%	No
OHIO									
Columbus	XX	X		$180,000	{2/81 10/81	Handicapped Adult Service Center	100%	100%	Cut services No
Akron	XX	X		$100,000	7/1/81	Cut Administration and Service Level	25%	20%	No--have applied for 10 grants
Cleveland	XX		X						
Cincinnati	XX	X		$92,000	7/1/81	Adult Work Activity	25%	13%	Yes--Community Serv.
Dayton	XX		X			Adult Day Care	33%		
OREGON	XX		X						
Portland									
PENNSYLVANIA									
Lewiston	XX		X			Handicapped Counsel.	25%		
Lancaster	XX	X		$ 9,000	7/1/81	Adult DD program	25%	13%	No--cut staff
Scranton	XX		X			Adult Activities	75%		
Erie	XX	X				Adult Day Care			No
Pittsburgh	XX	X		$13,631	7/1/81	Social Activities & Recreation for Severely disabled adults.	15%	13%	No
Pottsville	XX		X			Activities for adults	--Small--		
Johnstown	XX	X			7/1/81	DD Day Care (58 children).	50%	30%	No. Now a fee-for-service program and only able to open 4 days per week instead of the previous 5.
SOUTH DAKOTA									
Sioux Falls	XX		X				4%		
TEXAS									
San Antonio	XX		X						
Dallas	XX		X			Adult Day Care	16%		
Austin	XX		X			Adult programs	50%		
UTAH									
Salt Lake City	XX	X		$14,000	7/1/81	Summer Camp for Handicapped Chdrn.	22%	20%	No--prgms already cut 40% before
WASHINGTON									
Tacoma	XX	X		$13,000	7/1/81	Workshop, DD Activ.	33%	18%	No

CONCLUSION

Service programs for persons with disabilities, if UCPA is characteristic of the disability field, have frequently been protected by many federal, state, and local government legislative and executive agencies in comparison to other human services constituencies. The most vulnerable programs serving the disabled appear to be day community programs for both adults and children funded through Title XX Social Services contracts.

This survey did not include the loss of personnel assisted by the CETA program. CETA programs were reduced from $7.143 billion in FY 1981 to $3.003 billion in FY 1982. The President has proposed a further reduction in FY 1983 to $2.387 billion and CETA'S replacement with a new employment and training assistance block grant to the states. UCPA affiliates with CETA contracts are encouraged to document their experiences with the UCPA Washington office.

In a paper prepared for the UCPA governmental activities committee ("Congregate Housing Services Program: A Review of P.L. 95-557," February 1982), UCPA Professional Services Program Department Consultants Rachel Warren and George Gray documented several nonprofit organization recipients of HUD Section 202 housing construction loans who were postponing development because of the lack of available services financing. This could be the beginning of a slowdown or termination to deinstitutionalization efforts in several states.

UCPA affiliates are strongly encouraged to send their government grant and contract experiences to the UCPA Washington office. Only by accurate and complete documentation can we demonstrate to federal policy makers and analysts the real impact of federal budget reductions.

Word from Washington

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ATTACHMENT II

ARBITRARY REDUCTIONS OF DISABILITY ROLLS

Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) provide essential support to 4.5 million Americans who are so severely disabled that they cannot work. 1/

In March 1981, the Social Security Administration (SSA) began an accelerated review of the claims of people receiving these benefits. In an excess of fervor to reduce federal expenditures, Reagan Administration officials have created a process that is illegally leaving thousands of severely disabled Americans without any source of income for food and housing. Many are then relegated to the wards of public mental institutions or to dependency on county and state relief rolls.

Periodic review of disability cases is necessary, of course, to confirm that recipients continue to meet eligibility requirements and remain unable to work. However, the undersigned organizations contend that the Administration's current approach is contrary to both the letter and the spirit of the careful review that was mandated by Congress in the Social Security Disability Amendments of 1980.

In fiscal year 1982, 520,000 recipients of disability benefits will undergo review, compared to 400,000 in FY 1981 and 200,000 in FY 1980. The Administration plans to save $200 million in 1982 by drastic reductions in disability rolls based upon these reviews. 2/ State agencies, charged with the initial reviews, are under tremendous pressure, without adequate time to gear up and without enough staff to handle the increased load. As a result, reviews are often perfunctory, without adequate medical evidence and with insufficient attention to individual problems, as documented by the attached case examples.

These difficulties are compounded by pressure on administrative law judges and on Social Security personnel to quickly produce a substantial reduction in disability rolls consistent with Reagan Administration policy. For example, SSA has targeted for review the 65 administrative law judges who have the highest rate of findings that continue disability benefits. Only findings in favor of beneficiaries are being reviewed, not decisions terminating benefits. 3/ Similarly,

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1/ In addition, 1 million children and 500,000 spouses receive SSDI as dependents. Monthly payments to SSDI recipients average $413.57; SSI recipients receive $264.70.

2/ Social Security Administration, Improvement of the Administration of the Disability Program - Continuing Disability Investigations (CDI); March 11, 1981.

3/ January 7, 1982 memorandum from Louis B. Hays, Associate Commissioner of Office of Hearings and Appeals, SSA, to All Administrative Law Judges (January 7, 1982, Memorandum).

SSA is routinely reviewing 35% of decisions of state agency personnel in favor of beneficiaries, while only 5-7% of benefit terminations are reviewed. 4/

The review procedures are especially unfair to the mentally disabled. When a case is under review, the state agency mails the disability recipient a three-page form seeking detailed information about his or her medical condition and employability. If this form is not completed and returned within 35 days after being mailed, benefits are often terminated. The Mental Health Law Project, a Washington D.C.-based public-interest organization, has received reports from states across the country that, without help, many mentally disabled clients have trouble coping with the paperwork. Many are unable to understand that their only income is being threatened. They neglect to return the forms or complete them inadequately and, as a direct result of their disabilities, lose their monthly support. The problem is compounded by the SSA's practice of conducting these reviews without a face-to-face interview.

Although denial of disability benefits can be appealed, the appeals process does not adequately protect disabled Americans and their families. First, Social Security Disability Insurance recipients lose all benefits shortly after receiving a termination notice -- including Medicare, to which they are entitled after two years of disability. 5/ During the time their appeal is pending, which can be five months to a year, they receive no benefits. 6/ Even if benefits are then reinstated -- and that often takes several months after a favorable decision -- many severely disabled people will have already lost their homes or will have been forced to discontinue residential or treatment programs.

Moreover, an appeal requires presentation of medical and other evidence before the appropriate agency or before an administrative law judge or a court. Cutbacks in legal services and social service agencies have made it very difficult for disability recipients to obtain legal or other help. Again, the difficulties are multiplied for mentally

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4/ Interview with Jean Hinckley, General Counsel's Office, SSA.

5/ Supplemental Security recipients, however, are entitled to receive income pending appeal. But, with some exceptions, these benefits must be repaid if the appeal is lost.

6/ SSA has told a federal court in Kentucky that, because of the increase in workload based on the continuing disability review process, it cannot meet the 165-day (5½-month) time limit proposed by SSA in August 1980 and approved by the court. SSA is seeking a modification of that court order, freeing the agency from any specified time limit. Blankenship v. Secreta[illegible], HHS, 517 F. Supp. 77, 522 F. Supp. 618 (W.D. Ky 1981); see also January 7, 1982, Memorandum.

disabled recipients, who may not know where to turn for assistance and who, because of their chronic condition, often are utterly unable to present their own cases.

The Reagan Administration has attempted to justify the increase in benefit terminations as an economy. This is misguided. The human cost to disabled people and their families and the financial burden imposed on state, county and city governments far outstrip any savings realized by such harsh measures. For example, loss of disability benefits often results in costly rehospitalization of serious mentally disabled people who are unable to work and who lack sufficient income to live in the community. As two staff members of the New York Psychiatric Institute recently noted in a letter published in *The New York Times*, "This hospitalization costs the city, the state and the Federal Government $100 to $500 a day -- surely an odd way to save the approximately $15 a day that it costs to maintain a disabled person outside of a hospital with Federal disability payments." 7/ Other beneficiaries end up homeless and destitute and are forced to rely on hard-pressed state and local relief programs.

The organizations listed below believe that this nation must not thus abandon its disabled citizens. We therefore urge pursuit of the following recommendations:

1. *Congressional hearings, including field hearings, should be conducted as soon as possible*. These hearings should address the full array of issues in the disability review process.

2. *The General Accounting Office (GAO) should conduct an investigation of the Social Security Administration's practices relative to the continuing disability investigations*. The study should examine the immediate and long-range impact of current SSA practices on beneficiaries and on federal, state and local governments.

3. *Beneficiaries must not be terminated prior to a full and careful review of the merits of their case by appropriately qualified professionals*.

4. *Mentally disabled beneficiaries and those who are homebound must be provided with personal assistance (and home visits if necessary) throughout the review process*.

6/ Francine Cournos, M.D., and Richard Herman, "A Federal 'Shell Game' on Mental Disability," February 11, 1982.

Association for Retarded Citizens
Epilepsy Foundation of America
Gray Panthers, represented by the
    National Senior Citizens Law Center
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of Private Residential Facilities for the
    Mentally Retarded
National Association of Rehabilitation Facilities
National Easter Seal Society
National Mental Health Association
National Multiple Sclerosis Society
National Society for Children and Adults with Autism
Save Our Security Coalition

At its February 26, meeting, the SOS coalition's executive committee passed a resolution endorsing the above recommendations in their entirety. This coalition consists of nearly 100 organizations, including the AFL-CIO, National Council of Senior Citizens, National Education Association, Paralyzed Veterans of America, United Auto Workers, National Retired Teachers Association/American Association of Retired Persons and the American Federation of State, County and Municipal Employees.

For additional information, contact:

Jane Yohalem, Mental Health Law Project
2021 L Street, N.W.
Washington, D.C. 20036
(202) 467-5730

Myrl Weinberg, Association for Retarded Citizens of the United States
(202) 785-3388

The Mental Health Law Project (MHLP) compiled the following case examples. Pseudonyms have been used to disguise individuals' identity. For additional information and for referral to advocates representing disability recipients in these and other states, telephone Jane Yohalem or Lee Carty at MHLP, (202) 467-5730, or write to MHLP, 2021 L Street N.W., Suite 800, Washington D.C. 20036.

Arizona

Jim Hill is terminally ill with hystocytic lymphoma, a form of cancer. He began receiving disability benefits in 1979, after 16 years of work. His benefits were terminated in August 1981, based upon a finding that he had improved enough to work. Mr. Hill appealed and is still awaiting action on his appeal. He is surviving in the meantime on $156 per month from the state welfare department.

Roger Morris has a heart condition and is paralyzed on his right side, following a stroke. The stroke has also impaired his vision and his ability to speak. Mr. Morris' file was reviewed in October 1981. In November, the SSA declared him able to work and terminated both his benefits and his Medicare coverage. To support their two children, his wife now works seven days a week. Their telephone has been disconnected, they are behind on the rent and they have no medical insurance to pay for the care Mr. Morris desperately needs.

California

Larry Wallace has both a serious mental disability and chronic back pain. He is constantly depressed and unable to concentrate, hears ringing in his ears and suffers from delusions and paranoid feelings. He spends his time at home, isolated from virtually all social contact and is unable to understand and execute even simple instructions. His doctor has concluded that Mr. Wallace poses a substantial risk of suicide. Despite this severe illness, Social Security officials have informed Mr. Wallace that he is able to return to work. He received his last disability payment in January. Since then his wife and six children have been without support.

Anne Reed had a kidney transplant several years ago and must take steriod drugs to avoid rejection of the transplanted kidney. This medication produces back and joint problems, fungus infections and frequent bladder infections. She also suffers from cataracts. The consulting physician Social Security officials sent her to see found Mrs. Reed totally disabled. Nevertheless, she received a termination notice with the "impairment not severe" box checked.

Georgia

Charles Farley is nearly blind (only 21% of normal vision) and suffers from a severe back injury. He has had five operations to treat a herniated disc and is in tremendous pain. His condition is complicated by a dependency he has developed on pain-relieving drugs. Mr. Farley has been hospitalized 24 times in the past year. The consultant physician Social Security officials sent him to see failed to evaluate either his drug problem or his pain. Based on this doctor's evaluation, he was removed from the disability rolls in October 1981. His 16-year-old daughter left school and went to work full-time to support the family, but was fired recently when her employer discovered that she was not yet 18.

William Powell, an ex-military policeman, has extensive brain damage as a result of a gunshot wound, received when he intervened while off duty to break up a fight. The wound left him partially paralyzed on his right side and affected his vision and his memory. Mr. Powell's IQ has dropped to 57 -- low enough to classify him as permanently disabled. He also has a problem with excessive alcohol use. Social Security officials sent Mr. Powell to a consultant for a medical examination. During the 10-minute examination, Mr. Powell was not even asked to remove his clothes, which would have revealed substantial atrophy of his muscles on his right side. His benefits were terminated, based upon the results of this examination.

Indiana

Susan Blue suffers from severe mental illness. She has been hospitalized more than 10 times in the last 15 years. Ms. Blue is able to live in the community with the assistance of community mental health center staff. Someone must visit her at least once each day to make sure that she remembers to buy food. Ms. Blue has periodically tried to work but has always been fired because of her psychotic behavior on the job. Despite medical evidence that she is severely disabled, Social Security officials notified her last month that in their opinion she could return to work. She has received her last benefits check.

Samuel Rodgers has chronic schizophrenia. Without day-to-day supervision, he often forgets to eat. Despite this severe disability, Social Security officials informed him last year that, in their opinion, he was no longer disabled and could return to work. Mr. Rodgers appealed this determination, but without assistance in preparing his claim, he lost his appeal last December. He is surviving with the help of a local mental health center program.

Kansas

Daniel Cole suffers from a severe mental illness, diagnosed as paranoid schizophrenia and requiring treatment with large doses of the psychotropic drug Prolixin. Mr. Cole has been hospitalized at least six times for his illness. Before becoming disabled, he had been a truck driver. In January 1981, he tried to return to work, but his medication made him too drowsy to drive and, when he stopped taking the drug, he became disoriented and damaged one of the company's trucks. He had to stop working. The state vocational rehabilitation agency has refused to admit Mr. Cole to its program, finding him too disabled to work. However, Social Security officials terminated his eligibility in November 1981, on grounds that he had regained his ability to work the previous January, as evidenced by his brief and unsuccessful period of re-employment. No current information had been requested, nor was Mr. Cole's treating physician contacted. In February 1982, an administrative law judge found that Mr. Cole had been improperly dropped from the disability rolls.

Cynthia Johnson has severe mental disability that leaves her confused and unable to cope with stress. This, along with limited education, restricts her ability to perform even basic functions. For example, she is unable to keep track of the days of the week and confuses their order. Although the reports of her treating psychiatrist indicate she is disabled, she received a termination notice in December 1981. With the help of a legal services lawyer she is appealing the termination.

Louisiana

Paula Doyle has sickle cell anemia, requiring monthly blood transfusions, thrombophlebitis and ulcers. She also suffers from a back injury, the result of an automobile accident. Because of her sickle cell anemia, the surgery needed to correct some of her other medical prolems cannot be performed without endangering her life. Her doctor's assessment is that she is utterly unable to work. Nevertheless, Miss Doyle received a notice that her benefits had been terminated in September 1981. This notice of termination was her first communication from Social Security officials. She has not been asked for any information concerning her current condition and her doctor has never been contacted for an evaluation.

Bruce Brown is 11 years old. He has sickle cell anemia, complicated by an extremely serious nervous disorder. Bruce's condition makes it hard for him to take care of even his most basic physical needs. He receives monthly injections and has been placed in a special education class. Bruce's disability benefits were terminated in November 1981, without prior notice. Neither Bruce's parents nor his doctor were asked for information about his condition, nor was he sent to a consulting physician.

Massachusetts

Valery Small is a severely brain-damaged 16-year-old. Over the last few years, she learned to dress and wash herself and is in a special education class in the Boston public schools. In November 1981, Valery's family received a notice from Social Security officials stating that "based on [Valery's] work history, training and education, she is no longer disabled." With the help of a legal services attorney, Valery has appealed the termination.

Charles Lane has spent most of his life in a mental institution. Recently returned to the community, he lives in a rooming house and is able to get along only with substantial assistance. He remains hostile and has great difficulty relating to people. Moreover, Mr. Lane has never learned to read. On October 13, 1981, he received a letter from Social Security officials stating, "Because of your education, work experience and our evaluation of you, we find you ready to return to work." Mr. Lane's disability benefits were terminated on November 30, 1981. A legal services lawyer is helping Mr. Lane appeal his termination.

Minnesota

Hilda Christensen is mildly mentally retarded, with what is diagnosed as a "persistent paranoid personality pattern." She worked as a food handler and a home health aide, but was fired from every job. The local rehabilitation center evaluated her as not employable. Social Security officials, however, ignoring the overlay of mental illness on her mid-60s IQ, found that because she could dress herself and understand simple directions, she was not disabled. Her benefits were terminated and she is now existing on state general assistance money.

Catherine Mooney hallucinated throughout the examination by a Social Security doctor. Nevertheless, she was declared employable, even though, the report said, her "difficulty with hallucinations" is not helped by medication. Her benefits were terminated and she is now in the psychiatric ward of the local hospital.

Madge Green, 51, has been hospitalized twice in the preceding year for heart problems. Her breathing was impaired and she had arthritis. On July 23, 1981, she got a notice terminating her eligibility for disability benefits. When her appeal was heard on October 22, she was so obviously disabled that the administrative law judge stopped the hearing.

Missouri

Joan Young has both epilepsy and a severe mental disorder. She spent her childhood in a state mental hospital and, although now living in the community, is periodically hospitalized in a regional treatment center. Ms. Young was evaluated by a consulting psychiatrist hired by the Social Security Administration, who found her unable to relate to a supervisor or to other employees and to follow instructions, and therefore unable to work. Nonetheless, Ms. Young received a termination notice in April 1981. On the day her appeal was heard, she was too disoriented to find the building where the hearing was to be held. Carrying the name of her lawyer on a slip of paper, she eventually wandered into a legal services office. Other staff located the lawyer and assisted her in getting to the hearing. The administrative law judge found her "obviously disabled."

Mary Lewis, 61, fell and badly fractured her leg. Her doctor believes that the injury will probably never heal. She is in a leg brace and is given intensive physical therapy several hours each day. The injury has made it nearly impossible for her to leave her house. When she does go out, she must be carried into and out of the house. Yet her disability benefits were terminated in October 1981.

New York

A report prepared by New York City Council President Carol Bellamy, entitled Passing the Buck: Federal Efforts to Abandon the Mentally Disabled (January 1982), includes the following case histories:

Alan Palmer suffers from a severe psychiatric illness. A few days after being notified by Social Security officials that his benefits were being terminated and that he was "employable," Mr. Palmer was hospitalized as delusional and a danger to others. The director of the South Beach State Psychiatric Hospital, where Mr. Palmer was hospitalized, emphasized that Mr. Palmer's hospitalization resulted from "the stress of having his livelihood cut off." In the hospital's view, Mr. Palmer cannot work.

Jane Rollen suffers from chronic schizophrenia. She has been hospitalized several times for her psychiatric condition. Until January 1981, she was homeless and slept in the streets of New York City. She now lives in a residential program. Ms. Rollen also suffers from severe back pain caused by an injury. She attributes her back pain to possession by demons. In November 1981, Social Security officials found Ms. Rollen employable. She is appealing this determination with the help of counselors at her residential program.

Ohio

Gerard Linsey, 33, is mildly mentally retarded and brain-impaired. He also has severe psychological problems. Both Mr. Lindsey's doctors and the consultative psychologist he was sent to see by the SSA agreed that he was disabled. They concluded that he functioned well below the average and was unable to follow even simple directions. Nevertheless, Mr. Linsey received an SSA termination notice stating, "You can relate well to others and your memory is intact. Therefore you can work." The administrative law judge who reviewed Mr. Linsey's case found in the record no support whatsoever for the termination and reinstated Mr. Linsey's benefits.

William Brown has chronic pancreatis, peripheral vascular disease, liver disease, esophogeal disease, anemia, tuberculosis and chronic dementia. Yet the SSA notified him that, in the opinion of Social Security officials, he was able to go back to work as a manual laborer.

Carol Jones has a severe manic-depressive illness for which she has been hospitalized twice. Her psychiatrist's report indicates that she is isolated and withdrawn. Her illness induces anxiety so severe that her vision is blurred, she experiences frequent daily episodes of lightheadedness and she is unable to concentrate. The psychiatrist's report concludes that she cannot perform the most basic work activities -- she cannot relate to fellow workers, has difficulty understanding and following instructions, cannot maintain attention long enough to perform simple tasks and is unable to deal with even minimal stress. Not surprisingly, Ms. Jones failed to file an appeal within the proper time limit. Her disability benefits were terminated. Ms. Jones subsequently obtained representation by a legal services attorney and is now seeking reinstatement of benefits.

Pennsylvania

Fred Rowe is a chronic schizophrenic, paranoid type. To control his illness, he takes high doses of psychotropic medication. His condition is complicated by a spastic disorder which causes him to fling his arms around and a sleep disorder which leaves him drowsy much of the time, although he sleeps 16 to 18 hours a day. Mr. Rowe's 6'5" height, aggressive appearance and flailing arms present a threatening aspect to a potential employer. However, based simply on a review of his file, Mr. Rowe's disability benefits were terminated in November 1981. He was not interviewed by a Social Security official, nor was he sent to see a consultant. As a result of his loss of disability benefits, Mr Rowe's condition worsened and he has been hospitalized. He is pursuing an appeal.

Bernice Davis, 57, worked as a housekeeper until 1976. She has painful arthritis and a nervous disorder that manifests itself in anxiety so extreme that she lives as a recluse. Except for doctors' appointments, she rarely leaves her house. Last fall, Social Security officials found Mrs. Davis no longer disabled and ready to return to work. They made this determination without ever asking her treating physician for a report on her condition. Her benefits were terminated in November 1981. Mrs. Davis is seeking state-funded general assistance to survive while awaiting a decision on appeal.

Tennessee

William Thomas suffers from severe mental illness. When he received a three-page form from SSA asking for information about his illness and medical treatment, he scrawled disturbed, accusatory notes in the margins and returned the form to Social Security officials. Eight months later, Mr. Thomas received a letter notifying him that his disability benefits had been terminated because of his failure to complete the Social Security form. Further, he was told he would be required to repay benefits he had received in the eight months between the time he received the form and the date of his termination notice. Mr. Thomas is now institutionalized at Moccasin Bend State

Hospital. Thanks to the help of hospital social workers, he is back on the disability rolls.

Bruce White has multiple health problems: severe back pain from a slipped disk, ulcers, kidney problems, tuberculosis, a substantial hearing loss and anxiety. Both his physician and the consultant Social Security officials sent him to see agreed that he was so severely disabled that he could not do even sedentary work. Despite the extensive medical evidence in his file documenting his disability, he was dropped from the disability rolls in July 1981. In early December an administrative law judge ordered him reinstated. Nearly three months later, Mr. White is still awaiting his first benefits check.

Texas

Helen Pope is mentally retarded. She has been participating in a United Way agency's sheltered workshop program. Near the end of 1980, Miss Pope attempted to move to a Goodwill Industries workshop. After a month's trial, it was clear she could not manage the job, and she was sent back to the sheltered program. In March 1981, however, she received a benefits-termination notice, giving her 10 days to appeal. She didn't understand the notice and failed to file an appeal, whereupon her SSI benefits were halted for 10 months. With the assistance of a legal services attorney, she was finally reinstated.

Sidney Bell suffers from chronic schizophrenia, which is treated with frequent injections of Prolixin, an antipsychotic medication. Mr. Bell's intelligence tests at a low level. He rarely speaks and replies to questions with one-word answers. He lives in a boarding house. A Social Security consulting psychiatrist confirmed both the diagnosis of schizophrenia and Mr. Bell's poor adaptive and functional skills, but his benefits were terminated in March 1981. Thirteen months later, he still awaits a decision on his appeal.

STATEMENT OF BARBARA B. BLUM, CHAIRPERSON, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATION, AND COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, ON BEHALF OF THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATION, WASHINGTON, D.C.

Ms. BLUM. Thank you, Mr. Chairman.

I am Barbara Blum, and I am commissioner of the New York State Department of Social Services. I also chair the American Public Welfare Association's National Council of State Public Welfare Administrators, on whose behalf I am testifying today.

We very much appreciate this opportunity to convey our views on the fiscal 1983 spending reductions.

I would like to spend the brief time summarizing as briefly as I can the concerns of the administrators in the council and then complete the testimony with some recommendations which we believe would be useful in reaching the goals that you have mentioned today.

First of all, we wish to stress that with the reconciliation legislation last August the poor in this country have sacrificed a great deal. Our programs which include income maintenance, medicaid, social services, food stamps and energy comprise 6 percent of the budget, and the reductions were 11 percent.

Second, the States simply cannot absorb another large cutback in Federal aid without having to substantially reduce the assistance available to persons genuinely in need. The States do not have the resources to make up for the loss already sustained.

And third, we think it is premature to cut more of these programs now, while the effects of the changes made by last year's reconciliation legislation are just beginning to surface. At best, the changes have been in effect for 5 months, and that is not enough time to measure the impact of those massive changes.

The administration's fiscal year 1983 spending plan recommends 6.6 billion dollars' worth of reductions—an overall cut of 15 percent—in AFDC, medicaid, food stamps, low income energy assistance, social services, and child welfare. This is almost double last year's cut and far outweighs the share that these programs take of the Federal budget.

There are several points that really need to be stressed: The proposals would further impoverish what we have begun to call the truly needy. I think it is very, very important to remember that those persons receiving AFDC are largely children, and we are talking about 7 million of the Nation's children who require nurturing and shelter.

We need also to examine carefully what the changes forthcoming from the past session have done to work incentives. The fact is that with very modest supports we were able to sustain many of our clients in the work force and move them toward total independence. Now the incentives for those clients, the fiscal incentives at least, are almost totally diminished. I believe that most of those clients who have entered the work force will continue to stay in that work force, but I think it will be harder and harder to get future clients into the work force.

The proposals that have been forthcoming this year established very unrealistic work requirements. We have the current work requirements in place with new requirements added, while there is the proposal to reduce almost totally many of the employment funds that we have depended upon in order to prepare our clients for work.

The Council wants to stress most of all that the changes to date and the changes proposed have shifted costs and administrative burdens to the State. It has been almost a shell game. We know that we will not be able to sustain in the future the programs that had been most useful, because the States are not able to pick up the fiscal burden. Administrative burdens have been drastically increased.

We would suggest, as a council, that the focus be on those areas where the growth, either the relative growth or the rate of growth, has been the greatest. And we believe that major inroads can be made in the medicaid program. We have suggested now, for several years, the use of prospective budgeting. We believe that we should have greater incentives to the States for third-party recoveries, which we think will be very beneficial. We support an optional arrangement for States to charge medicaid recipients nominal copayments, because we believe that there would be advantages in terms of the way the medicaid system is to be used.

I would just like to conclude by saying that there are other changes in the AFDC and the food stamp programs that could be very beneficial. If we could have administrative simplification in those programs, if we could work with Congress to look at our overall objectives and goals for the needy persons of this Nation, I believe that we actually could see savings in the future.

Finally, we strongly support a heavy emphasis on new kinds of employment programs for our clients.

Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF BARBARA B. BLUM, CHAIRPERSON, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, AND COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Mr. Chairman and members of the Committee, my name is Barbara B. Blum, and I am commissioner of the New York State Department of Social Services. I also chair the American Public Welfare Association's National Council of State Public Welfare Administrators, on whose behalf I am testifying today. We very much appreciate this opportunity to convey our views on the fiscal 1983 spending reductions the Reagan Administration has proposed for the human service programs within the Finance Committee's jurisdiction.

The Council is composed of the public officials in each state, the District of Columbia, and the U.S. territories charged with the responsibility for administering programs to help the poor meet their basic needs and, when and where possible, overcome or reduce their dependence on government aid. Among the programs we manage are aid to families with dependent children (AFDC), Medicaid, food stamps, low-income energy assistance, social services, and child welfare. Since its beginning more than 40 years ago, the Council has worked actively with the Congress and the Executive Branch to develop sound and progressive social policies and to assure their responsible and effective administration at all levels of government. The thorny issues President Reagan has laid before you in his FY 83 budget confront those of us working in the human services every day. We hope our experience and expertise will prove helpful as you determine how best to control federal spending yet still protect and enhance the lives of less fortunate Americans.

Let me begin by saying that state human service administrators object to further sweeping changes in programs serving needy people. There are three reasons for this.

First, we believe that, with passage of the reconciliation legislation last August, the poor in this country have already sacrificed more than they ought to have in the name of economic recovery. The reconciliation act cuts more than $3.6 billion this year from the core welfare programs--a cut representing almost 11 percent of the total $35 billion reduction--and promises to save the federal government considerably more in the years ahead. Yet, these programs--AFDC, Medicaid, food stamps, low-income energy assistance, social services, and child welfare--constitute less than 6 percent of the total federal budget. Is it fair, then, to further slash the benefits and services on which the poor depend? We urge you to say no.

Second, the states simply cannot absorb another large cutback in federal aid without having to substantially reduce the assistance available to persons genuinely in need. By and large, the states do not have the resources to make up for such a loss. Indeed, the economic situation in many states is worse than that of the nation as a whole, and the prospects for rapid improvement appear dim. Additionally, the administration has put forward a "new federalism" initiative designed to sort out federal and state responsibilities. Until the contours of this proposal are clear, states believe that making further reductions in grant-in-aid programs would be ill-advised.

And third, we think it would be premature to cut more from welfare programs now, while the effects of the changes made by last year's reconciliation legislation are just beginning to surface. At best, these massive changes have only been in place five months. Is that enough time for any of us to feel confident that another round of wide ranging revisions won't cause more harm than good? If anything, what we do know about the fallout from the reconciliation act suggests there is ample room for skepticism about major new changes that are intended to save money. To take just one example from my own state of New York. In Monroe County, where Rochester is located, 130 families lost their day care subsidy last year owing to cutbacks in Title XX funding: within six months of being notified of this change, fully a fourth of these families began receiving AFDC or food stamps. While we cannot be sure at this point, common sense suggests that similar adverse consequences are occurring elsewhere. In any event, until more is known one way or the other about the actual effects of the spending reductions that have already been made, additional major cuts would, in our judgement, be a step in the wrong direction.

The administration's FY 83 spending plan recommends $6.6 billion worth of reductions--an overall cut of 15 percent--in AFDC, Medicaid, food stamps, low-income energy assistance, social services, and child welfare. This is almost double last year's cut and far outweighs the share these programs take of the federal budget, as the chart on the following page indicates. The administration offers most of the same arguments for retrenchement it made a year ago: force welfare recipients to support themselves; eliminate duplicate benefits; focus assistance on the most needy; promote better management by the states; and reduce federal intrusion in state affairs. Our experience tells us otherwise.

While we believe some of the proposed changes merit consideration, most of the administration's recommendations would punch holes in the so-called social safety net through which large numbers of truly needy people may fall. More specifically, after careful analysis, the state administrators find that the FY 83 proposals would: further impoverish the poorest people; create disincen-

CUTS IN CORE WELFARE PROGRAMS FY 82-83

	I FY 82 Estimated Outlays Prior to Reconciliation	II Appropriation or Continuing Resolution for FY 82 (Assumes cuts)	III FY 82 Estimated Federal Savings (Column I Minus Column II)	IV Current Services[1] Estimate for FY 83	V Reagan's Proposed Outlays for FY 83	VI FY 83 Estimated Federal Savings (Column IV Minus Column V)
Aid to Families with Dependent Children	8,215.9	7,291.8	- 923.9 (11.2)*	7,465.0	6,309.9	- 1,155.1 (15.5)*
Food Stamps	12,473.0	11,200.0[2]	- 1,273.0 (10.2)*	12,600.0	10,400.0	- 2,200.0 (17.5)*
Medicaid	18,312.0	17,623.8	- 688.2 (3.8)*	19,859.0	17,845.0	- 2,014.0 (10.1)*
Social Services Block Grant	3,086.0	2,400.0	- 686.0 (22.2)*	2,450.0	1,974.0	- 476.0 (19.4)*
Low Income Energy Block Grant	1,850.0	1,875.0	+25.0	1,936.0	1,300.0	- 636.0 (32.8)*
Child Welfare	568.7	465.6	- 103.1 (18.1)*	465.0	380.0	- 85.0 (18.3)*
Welfare Subtotal	44,505.6	40,856.2	3,649.2 (8.2)*	44,775.0	38,208.9	6,566.1 (14.7)*
Total Federal	739,300.0	725,300.0	35,190.0 (4.8)*	799,000.0	757,600.0	43,000.0 (5.4)*
Welfare Subtotal as % of Federal Total	6.0%	5.6%	10.4%	5.6%	5.0%	15.3%

*Figures in parentheses in Columns III and VI indicate the percentage reduction.

1. Column IV is the Reagan administration's estimates of how much would be spent in FY 83 if current service levels were maintained.

2. Although the current FY 82 Food Stamp appropriation is only $10.3 billion, Congress is expected to approve a $1 billion supplemental appropriation soon.

tives to work for welfare recipients, impose work requirements that cannot be met, and shift significant costs and administrative burdens to states. Let me address each of these criticisms in turn.

Further Impoverish the Truly Needy

To come up with this year's larger cuts, the administration has had to recommend slashing benefits to people who would be considered truly needy by even the most conservative standards. Two of its proposals would hit especially hard. By reducing AFDC and food stamp benefits according to the amount of energy assistance received and increasing the food stamp benefit reduction rate, nearly all welfare families would be made poorer. I mention food stamps here, even though the program is not within this Committee's jurisdiction, because most AFDC families receive them and, thus, would be affected by the proposed food stamp changes.

According to research by the University of Chicago's Center for the Study of Welfare Policy, the FY 83 AFDC and food stamp proposals would, on average, drop the disposable income of welfare families in which the parent is not working, from 75 percent to 72 percent of the poverty line. We believe most of these families would be mothers with young children. Our own study of the likely impact of the proposed changes, while not yet completed, tends to confirm the Center's finding. For example, the state of Kansas has predicted that the disposable income for the typical AFDC family of three, where the mother does not work, would decline from 78 percent to 72 percent of poverty. In Oregon, this same typical family would see its income fall by more than 9 percent. It is important to keep in mind here that we are talking about families with incomes that fall considerably short of the amount the federal government itself has defined as necessary for subsistence. Further cuts in benefits to these families would only diminish their already inadequate incomes. We fail to see the logic in the proposals to count energy assistance as income and raise the food stamp benefit reduction rate. We do not believe energy payments duplicate AFDC and food stamps, as the administration contends. The energy program was explicitly created by the Congress in recognition of the fact that the poor do not have sufficient incomes to meet the rising cost of heating and cooling their homes. As for increasing the benefit reduction rate from 30 percent to 35 percent, this will just further reduce the already declining ability of poor households to purchase food.

The substantial cutbacks in social services, child welfare, and Medicaid proposed by the administration could also eventually result in the loss of benefits to the poorest people. As I noted earlier, many states are even more financially strapped than the federal government. It would be impossible for them to come up with the funds needed to offset these spending reductions and to thereby preserve all essential services.

Create Disincentives to Work

Spurring welfare recipients to work is a theme often sounded by the administration, but its FY 83 proposals would, in our opinion, do relatively little to advance this theme. Indeed, we believe that these proposals, when combined with the changes made by last year's reconciliation act, may make the financial reward of working so small for many AFDC recipients, they may be forced to choose to rely totally on public assistance and protect their eligibility for Medicaid and social services.

The major work disincentive contained in the administration's FY 83 budget is the proposal to completely eliminate the earned income disregard food stamp recipients get when they work. This disregard is now 18 percent of earnings, having been reduced from 20 percent by last year's budget-cutting efforts. Adding its elimination to the apparent disincentives built into AFDC by the reconciliation act--standardized work expense and child care deductions below actual costs for these items, elimination of the work incentive disregard (i.e., $30 plus one-third of remaining income) after four months, taking this work incentive disregard off of net rather than gross income, and limiting eligibility to a family with gross income at or below 150 percent of a state's need standard--and to the new proposals for counting energy assistance and upping the benefit reduction rate, would be tantamount to imposing marginal tax rates above 100 percent on many working welfare recipients. We cannot understand why the same president who has so vigorously advocated reduced taxes for the rest of the nation--as a way to encourage savings and hard work--would suggest raising taxes to confiscatory levels for the poor, by reducing their income if they work.

The University of Chicago research indicates that the income of the average AFDC working mother would drop from 81 percent to 73 percent of poverty, if the administration's proposals become the law of the land. Even more startling is its finding that in 24 states this mother would actually end up with less disposable income than the mother who does not work. Again, our own study tends to substantiate this, with states predicting income losses to the typical AFDC working mother that range from 14 percent to 22 percent. Not surprisingly, our study also reveals that the average earnings of a working recipient have declined significantly since the 1981 reconciliation act changes went into effect. This may mean the typical AFDC working mother is now either holding down part-time employment or working in a job that pays very poorly--the type of welfare recipient, one assumes, who most needs incentives to remain in the labor market.

Establish Unrealistic Work Requirements

The National Council of State Public Welfare Administrators has always favored strong work requirements for employable welfare recipients. However, the new work requirements the administration proposes will raise expectations that simply cannot be met, so long as federal resources for helping AFDC mothers secure jobs that pay a living wage continue to shrink.

For many recipients who are not now working (or not working enough), the states would be mandated to impose strict new work requirements, while sustaining a substantial loss in federal funds for carrying out the current work requirements. Money for the Work Incentive (WIN) program--the only source of funds used exclusively for helping AFDC parents obtain employment--would be totally wiped out, despite the fact that only last year the administration agreed, at the urging of Congress, to let states demonstrate more effective ways to operate WIN. Additionally, the federal reimbursement states receive for the cost of administering AFDC, food stamps, and Medicaid would be cut by five percent below current funding. Nonetheless, states would have to operate expensive community work experience (workfare) programs; to require AFDC and food stamp applicants to search for jobs while their applications are being processed; to remove parents from AFDC when the youngest child reaches age 16 without providing any training or job search assistance to them; to require parents who receive AFDC because they are unemployed to participate in workfare; to remove from AFDC parents who voluntarily quit their jobs or reduce their earnings, even those who are not by law required to work; and to penalize those who refuse to participate in the state's work programs.

Although states might like to test some of these requirements, such as job search for applicants and sanctions for parents who refuse work, the administration's recommendations would not be universally successful in all states and could not, in any event, be effectively carried out without federal resources. With the nation's unemployment rate hovering near 9 percent, there are in many states few, if any jobs that welfare recipients can be compelled to take. And, the alternative to private sector employment--workfare--costs money to set up and operate. Based on very rough estimates we have made, it might cost the states and the federal government as much as half a billion dollars in FY 83 to operate workfare programs and administer the other proposed work requirements. Where will this money come from, if funding for WIN is eliminated and administrative dollars are federally capped? The states cannot do the job without an adequate federal financial commitment.

Shift Costs and Administrative Burdens to States

The work requirements are but one example of the tendency in the administration's FY 83 budget to shift more financial and administrative responsibility for welfare programs to the states. Let me address the problem of cost shifting first.

Almost half of the $6.6 billion in recommended welfare savings would be achieved by merely transferring costs to the states; a questionable strategy made all the more troublesome by the fact that most states cannot absorb these costs. Eight examples of this cost-shifting theme come to mind:

- As already noted, all funds for the WIN program are to be eliminated, saving the federal government $245 million--yet more people will be subject to work requirements.
- The energy assistance and AFDC emergency assistance programs are to be

combined, with funding cut by 33 percent, for a federal saving of $636 million--yet there is no evidence that the poor will have any less need for this assistance come next Winter.

- The federal matching rate for optional services and optional populations under Medicaid is to be trimmed by 3 percentage points, saving $600 million in federal money--but doing nothing to address the main reason Medicaid expenditures continue to rise; inflation in the health care marketplace.

- Federal matching for states that buy Medicare Part B coverage for Medicaid recipients is to be entirely eliminated, producing $203 million in federal savings--although the Medicare buy-in has proved to be one of the most economical ways to assure good care for those Medicaid recipients who qualify for it.

- The enhanced federal matching rates for family planning and nursing home inspections under Medicaid are to be stopped, in order to cut federal costs by $64 million--yet, these services are mandated by federal law, which was the reason for providing higher matching in the first place.

- The Title XX social services block grant is to be reduced from its current level, $2.4 billion, to $1.974 billion, a cut of 18 percent--despite the fact that Title XX is essential to helping the poor become more self-sufficient and to caring for those who cannot care for themselves.

- Similarly, funds for child welfare services, foster care, and adoption assistance are to be cut from $465 million this year to $380 million next year, a reduction of more than 18 percent, and consolidated into a block grant--yet, even current funding levels for these programs are insufficient to meet the pressing needs of children and their families.

If states cannot make up for these losses, who will? Most localities are no better off financially, and leaders in the private sector have made it clear that their organizations are in no position to fill the gap.

The FY 83 budget would also transfer costs by imposing additional administrative burdens on states, while actually decreasing the federal share of state and local administrative costs. Put simply, states would have more to do but less money with which to do it. The administrative burdens would come in two forms.

First, in AFDC especially, states would be required to administer a number of new, program-complicating rules designed to reduce eligibility and benefits, in addition to the work requirements I have already mentioned. For example, states would have to: (1) reduce the AFDC family's benefit by the amount of rent the family presumably does not pay when it lives in a larger household with others; (2) assume that the income of other unrelated persons living in the same house is available to the AFDC family (a proposal rejected by the Finance Committee last year); (3) count toward the needs of the AFDC family the income of related, minor children who are not AFDC recipients (e.g., those receiving social security or child support); and (4) as previously noted, offset AFDC and food stamp benefits according to the amount of energy assistance a household gets. All of these proposed revisions, depending on how they were written into law, could further complicate administration, and would come on the heals of the numerous 1981 reconciliation act changes, which states are still implementing.

Second and most important, on top of these new requirements, the administration would require states to meet a 3 percent tolerance for AFDC, food stamp, and Medicaid errors in FY 83. States would lose federal funding for any errors above this level, and by FY 1986 would be expected to have reduced our errors to zero in all three programs. How does one argue against such an ingenious proposal? Who favors increased errors? Yet, it is impossible to eliminate all errors. Only under ideal circumstances with ideal programs could a zero error rate be achieved--a situation which will never be realized. The incidence of client-caused errors, the existence of error prone policies such as those I have just noted for counting other presumed sources of income, a federal definition of error in AFDC that is so broad the majority of countable errors do not involve the mispayment of funds, and the constant introduction of staff to new policies and procedures stemming from the frequency with which the federal government changes these programs--all assure that errors will occur, even in the best run programs. States have made significant progress in reducing errors; the AFDC error rate has been cut in half since 1973 and now stands at approximately 8 percent; the Medicaid error rate is a low 5 percent, down from a little more than 6 percent in 1978 when Medicaid quality control began; and the current food stamp error rate, 13.3 percent, is more than ten percentage points lower than it was in 1974. Yet, despite this progress, the administration's proposed error rate policy would end up penalizing all 50 states, further reducing the already limited funds needed to provide benefits to the poor.

The administration's proposal to combine and cut funding for the expenses of administering AFDC, Medicaid, and food stamps would only compound the difficulties states face in operating economical and effective welfare programs.

The loss of funds could be felt most acutely by states now developing automated management information systems, which have proved to be the single most successful way to hold down costs in the long-run. There can be no question about one thing: it takes money to reduce errors and manage constantly changing programs. Placing a lid on administrative funds would only limit the states' ability to run these programs properly, increase the chances of error, and force states to bear an unfair burden in what are now jointly financed and administered programs.

While it is clear by now that we oppose most of the Reagan Administration's FY 83 recommendations for changing welfare programs, I want to identify for the Committee those proposals we think warrant further discussion as well as some of our own ideas about how to control federal spending. I want it to be understood, however, that states would be content with no further changes in the coming year. Basic welfare programs and the people they serve have already endured more than their fair share of budget cuts. Nevertheless, we know you are seeking alternatives and, thus, hope that our suggestions will be persuasive, should you determine that additional cost-saving actions are necessary.

I would like to organize our suggestions into four categories: promoting equity, encouraging work, strengthening administration, and controlling Medicaid costs.

Promoting Equity

Inequities in the way people are treated by welfare programs have long frustrated policymakers and program administrators and will probably continue to in the foreseeable future. Certain of the administration's proposals, if designed to minimize their administrative burden, may help to reduce these inequities some. In AFDC, we think it makes sense to establish a standard household definition that includes the parent(s) and all minor children who are not receiving SSI and to require parents in the military to contribute financial support to their children on welfare. These changes would adjust benefits to more accurately reflect a family's true financial circumstances. For the same reason, we also support the idea of permitting states to defray the cost of caring for a Medicaid recipient in a nursing home by securing reimbursement from close relatives and by enforcing liens on the recipient's home once it is no longer in use. Families of nursing home recipients should help pay for this care if they are financially able to do so.

Encouraging Work

As I alluded earlier, we think there would be value in giving states the option to require job search by welfare applicants and to financially sanction expected-to-work AFDC parents when they voluntarily quit their jobs or reduce their earnings, so long as states have some leeway to exempt parents for good cause. If adequate federal funds for day care and the operation of work programs can be made available, the state administrators would also like to have the general authority to require AFDC mothers to participate in these programs when their youngest child reaches age three. Mothers with young children on AFDC are often young themselves and should be helped to acquire the skills and training needed to compete in the labor market, before they become too dependent on welfare. In addition, while we oppose the administration's recommendation to shorten from four months to 30 days the automatic extension of Medicaid eligibility for persons who have worked their way off AFDC, we believe the concept has merit. As an alternative, we would suggest letting the states determine the length of the extension, up to four months, since it may often take longer than 30 days to secure private health insurance.

Finally, we would urge Congress to give a high priority to work programs for welfare recipients, for in the long-run this may be the most cost-effective investment you make. Without this investment, we believe many welfare recipients may be relegated to permanent dependence unnecessarily.

Strengthening Administration

We would offer three suggestions in the interest of simplifying welfare program administration. First, instead of completely eliminating professional standards review organizations(PSROs) and the hospital utilization requirement, as the administration proposes, we would recommend a more flexible approach: allow states to drop the federal hospital utilization review requirement if they believe it does not work for them but continue funding those states that find the method effective in controlling utilization, and require hospitals to continue monitoring the use of their services Second, we would urge Congress to make the AFDC and food stamp programs more compatible administratively, given that these programs serve many of the same people. Discrepancies between AFDC and food stamp requirements are a major source of error that could be at least partially removed by defining terms in the same way for both programs. And third, we believe the federal practice of threatening states with penalties for supposedly poor performance is ineffective, arbitrary, and breeds ill will between the different levels of government. Perhaps a better way to improve administration would be to give states rewards for good performance, as is currently being tried in the food stamp program. It would be possible, we think, to design such a policy so that it would not cost the federal government any additional money and in the long-run would probably yield significant savings.

Controlling Medicaid Costs

There are few programs that worry federal and state officials more than the increasingly expensive Medicaid program. Last year, in pushing through the reconciliation legislation, the Congress consulted closely with the states and adopted a long-term plan for trying to bring Medicaid costs under control. In the interest of furthering that plan, we have the following suggestions to make.

First, allow states that use prospective reimbursement or other cost-saving methods to reimburse hospitals and long-term care facilities under Medicaid to apply the same reimbursement approach to Medicare-funded institutions. Medicare is a much bigger financier of health care than Medicaid, yet it still reimburses on an actual cost basis, which provides no incentive for cost control. We believe that a state which has successfully curbed the growth of Medicaid costs through an alternative reimbursement system should be encouraged by federal law to apply the same system to Medicare. This would help to contain Medicare spending and would also place a significant portion of the state's hospitals under a more economical reimbursement arrangement.

Second, give states incentives to pursue third party recovery. We believe it would be cost-effective to encourage states to identify and collect from other health benefit programs, such as private insurance and Medicare, which are responsible for covering Medicaid recipients. Administrators believe that several times more dollars are lost to Medicaid in the form of such uncollected third party funds than to fraud and abuse, yet federal financing of fraud and abuse control is much higher. Raising the match for third party recovery to a comparable level would give many states the resources they need to make recovery pay off. At the very least, we believe the incentive for third party recovery contained within the reconciliation act should be continued beyond FY 82.

Finally, permit states to charge Medicaid recipients nominal copayments when they use mandatory services. We believe that copayments may help to stem the inappropriate use of such services, but the administration's proposal to mandate them would be unwise, given the significant differences in services provided and populations covered from one state to the next. Instead, it would be better in our judgment to grant states flexibility to decide which services would be subject to copayments, at what levels they would be set, and which groups of recipients would be affected by them.

I realize many of these ideas are sketchy, but I hope I have been able to give you a sense of our alternatives. As always, the council of state administrators would be more than happy to help further develop those proposals in which the committee is interested.

Thank you for this opportunity to testify, Mr. Chairman. That concludes my statement.

The CHAIRMAN. Well, as you probably know, I have an interest in the food stamp program too, as chairman of the Nutrition Subcommittee. I particularly appreciate that last suggestion because I think there are areas in the administration. I am not certain whether we can cut the program much more, but we can probably save money in some of the areas you suggest, and I will take you up on that offer to try to be helpful.

Ms. BLUM. Well, I will be available.

The CHAIRMAN. Of course, we have AFDC here. The programs do work in tandem, and we ought to be looking at both instead of one here and one over in the Agriculture Committee.

Plus, the suggestions that you made for medicaid I think are some that we are considering now; in fact, I know they are some we are considering now.

I appreciate the willingness of both witnesses to be helpful. No one wants to cut any programs that will impact, at least I don't, adversely on some needy person. But I guess there are two categories—maybe there are more than two—the truly needy and the truly greedy. We get some of each. Now, I am not saying anybody here was in the latter category today. Maybe tomorrow or the next day somebody will drift in in that category to talk about leasing and some of those big provisions where they get hundred billion dollar refunds. They might be in the "truly greedy" category. So, we have to sort out all of the different proposals, and I am glad that we did adopt three of your suggestions. Are we working on some other suggestions?

Ms. **Blum**. Senator, you have stressed so clearly your desire to hear ideas about how we might save dollars in the programs that we administer, and none of the administrators are protective of these programs. We do want to work with you.

In my own state over the last 4 years we have managed to stabilize and, in some parts of the State, reduce the caseload by stressing work, but in a very positive way, not in a workfare kind of way which is so often not productive and creates a great deal of administrative burden.

We do believe that there are ways to break through with these programs. They are dated programs. We can reshape them and spend less money and get far more for the dollars that you appropriate.

The **Chairman**. Right. I believe that, and I think other members do, because you are working with the programs on a daily basis. Maybe once or twice a year or maybe once or twice a month we focus on a program for 30 minutes or 40 minutes, and then it is sort of forgotten. We make judgments sometimes that you certainly wouldn't make, and you might reach a better goal than we would. We may make a wrong decision. So there are areas that you can suggest to us that we ought to focus on.

I think the same is true of the administration; although, obviously, any administration has experts in different fields, more than we might have in the Congress. But we believe we have a lot of expertise on both sides of the committee as far as our staff is concerned. We are willing to look at any meaningful recommendation, willing to drop any administration proposal if we can find some offsetting idea that has more merit. Many times that doesn't have to be very good.

Mr. **Smith**. For example, Senator, 1 of our 15 recommendations dealt with overly-restrictive regulations for intermediate care facilities. We worked with the various staffs in an attempt to simplify and reduce some of those unnecessary medically-oriented regulations such as doctor visits which were too frequent.

So there are many small ways which add up, which we would be pleased to offer in the process.

The **Chairman**. Well, thank you very much. Your statements will be made part of the record.

If there are other people in the audience who wanted to submit statements, the record is open.

[The prepared statement of the National Council of Health Centers follows:]

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STATEMENT
OF THE
NATIONAL COUNCIL OF HEALTH CENTERS
TO THE
SENATE FINANCE COMMITTEE
ON THE
ADMINISTRATION'S PROPOSED FY 83 HEALTH BUDGET
SUBMITTED FOR THE RECORD

March 16, 1982

The National Council of Health Centers is pleased to have this opportunity to express our views on President Reagan's proposed budget for fiscal year 1983. Our comments will address those areas that directly or indirectly affect nursing homes as well as elderly Medicare and Medicaid beneficiaries.

The National Council of Health Centers is the national association representing multifacility nursing home firms with more than 170,000 nursing home beds in 49 states and the District of Columbia. Our members also provide a number of other health-related services including home health, adult day care, drug and alcohol rehabilitation, and retirement communities.

During the debate last year over the Administration's fiscal year 1982 budget, the National Council publicly supported the goals of the Administration's economic recovery program. In a telegram to President Reagan we stated, "We strongly endorse your proposal to shift the burden of health care delivery back to the free market place and support the inclusion of long term care services in that proposal. By allowing competitive forces to control costs and by easing the present tremendous regulatory burden, you will provide us with the new beginning that we so desperately need."

Today, one year later, we still firmly believe that a major reorientation of the health care system is in order with a shift in focus to private sector initiatives and the principles of competition through a prospective payment system.

We have come to rely too heavily on government for all the answers to our health care needs, at the same time expecting that it will pay for all these needs. As a result, programs have grown without the benefit of a cohesive long range policy or objective and expenditures have risen out of all proportion to that originally anticipated.

A more rational and logical approach is to define in advance government's role, the basic package of benefits which will be supplied, the population to be served, and the payment which will be made for those benefits. While this may sound simplistic, it is illustrative of the root of our problem: expectations with regard to coverage and benefits are unrealistically high and only lead to frustration when, for example, a Medicare beneficiary finds that only 38% of his medical costs are covered. The name given to these programs-- "entitlement" is indicative of the general attitude that one is entitled to coverage of all his needs, yet given our economy's current condition the government clearly cannot afford that type of open ended liability.

At the same time, providers are caught by an inefficient and uncertain reimbursement system with cost disallowances, non-covered costs, and the lack of incentives for efficient performance. The nature of the system has spawned regulations, oversight and endless paperwork for the purposes of monitoring and overseeing the inefficient system.

As providers very much involved in providing a wide range of long term services, we have begun to explore alternative sources of funding for long term care and the appropriate roles of federal and state governments and the private sector. Essential to this process is the development of a payment system for government programs which is designed to stimulate the utilization of the most cost effective and appropriate health care services by the recipient. If this new proposed prospective payment system can be based on the competitive principles of the private marketplace, then by its nature, it will constrain costs.

We are encouraged that the Administration is not content with continuing the old inefficient and costly Medicare methodology. As the members of the Committee know, Medicare's retrospective departmental cost based system only invites piecemeal cutting of benefits and tightening of cost limits each year as expenditures for health programs increase beyond any projections made. Many of these increases are inevitable as technology improves, as the number of elderly eligible for benefits grow and demand more services. The certainty of these factors force major new approaches and proposals. Unfortunately in awaiting the Administration's new proposals, we are once again faced with more cuts and losses of benefits. We can only hope that the Administration will move quickly and that Congress will act swiftly in enacting these new initiatives because clearly neither states, nor providers, nor beneficiaries can continue from year to year as they have been with the uncertainty which currently prevails.

With these comments as an overview we would like to address specific proposals contained in the FY 83 health budget.

MEDICARE PROPOSALS

Equalization of Rates for Hospital Based and Free Standing Skilled Nursing Facilities and Hospital Based and Free Standing Home Health Agencies.

We are very supportive of this proposal for the reason that it makes no sense to pay higher rates for the same services to Medicare SNF patients merely because they were delivered in a hospital setting. Last year the average Medicare rate in a free standing skilled nursing facility was $45.36, while for a hospital based SNF, the average was $93.92.

The great difference between these two rates is also reflective of the inefficiencies of the Medicare cost reimbursement system, a system we believe should receive the highest priority in reforming the Medicare program.

Elimination of Waiver of Liability

The passage by Congress of legislation in 1972 enacting waiver of liability provisions and presumed coverage were symptoms of the already evident problems with Medicare's retrospective cost reimbursement system. Providers--hospitals and nursing homes--had to make the determination of whether a patient was covered by Medicare and they were then at risk for that decision. If a clerk in an intermediary's office disagreed with that decision, the provider in effect was punished by being denied payment for that patient's care.

Realizing perhaps that this policy put providers in an unfair position, Congress enacted provisions for Presumed Coverage and Waiver of Liability in Public Law 92-603. Last year Congress repealed the Presumed Coverage Provision and now the Administration proposes to do the same for Waiver of Liability.

From the perspective of skilled nursing homes, unless a prospective payment system for Medicare is enacted swiftly, the elimination of Waiver of Liability will all but eliminate the Medicare SNF program as well. Providers will have no recourse for any mistakes or disagreements regarding retrospective determinations in coverage.

A 1979 report by the New York State Office of Health Systems Management points out that Medicare specifically allows for presumptive coverage of Medicare benefits on the basis of a physician's certification of SNF level of care need. While this certification does occur, it is not accepted as a final decision, nor do most physicians sufficiently understand the intricacies of eligibility to correctly inform their patients. As a result patients are frequently told by their physicians that they will be covered, and they are almost always disappointed. Unfortunately, explanatory pamphlets distributed by federal agencies do little to dispel these expectations.

A report compiled by a Medicare Task Force of the Minnesota Foundation for Health Care summarized the perceptions and misperceptions about the Medicare program held by concerned parties in that state. Physicians commonly believe that all their patients' skilled care is covered by Medicare for up to 100 days. Consumers expect that any nursing home care will be covered for 100 days. Unfortunately, both of these perceptions are far from the truth as only about three percent of the patients in nursing homes are covered by Medicare and the average length of stay is only 24 days.

Prospective reimbursement would do much toward resolving some of these problems, but not other problems such as the overly restrictive definition of skilled care or the hospital backlog.

Hospital Backlog

A significant problem exists in the so called "hospital backlog" of patients in hospitals awaiting nursing home beds. One need only look at the number of states reporting serious backlogs of hospital patients awaiting a Medicare or Medicaid nursing home bed to appreciate the magnitude of the problem. These states include, to name only a few, California, Washington, Georgia, Massachusetts, Connecticut, Michigan, Minnesota, New York, and the District of Columbia. Data from individual states is supported by further national data indicating that 250,000 administratively necessary hospital days were used in the first quarter of 1979; and that "backup patients" average ten percent of a hospital's occupancy. Little computation is needed to figure savings to be gained by substituting a $45 per day rate in a nursing home for a $300 daily rate in a hosptial. The cost to the Medicare and Medicaid programs for these administratively necessary days has been estimated at $1.5 billion.

There is little incentive for hospitals to discharge these patients who are at an inappropriate level of care, and since there is no copayment until the 60th day of hospitalization, there is no reason for the patient to want to be discharged.

Maintaining hospital occupancy can be a critical factor especially when occupancy rates nationally remain at 75%. An HHS Region 10 study noted the effect of low hospital occupancy levels by citing the policy in one state to penalize through lower reimbursement, hospitals with occupancy rates less than 85%. The report states "Where there is a deliberate penalty, there is certainly an economic incentive to maintain occupancy rates".

This disincentive to discharge has been one of the reasons for the hospital backlog nor do we see the situation improving as reimbursement limits are tightened further and if utilization review is eliminated. If both PSRO and UR are abolished there will be no mechanism for identifying these patients and for assuring that they get transferred to a less costly and more appropriate level of care.

Three-Day Stay

One way of saving Medicare and Medicaid dollars is to assure not only that hospital patients are discharged in a timely manner, but also that they never enter a hospital unnecessarily. That is precisely what S.1507, the elimination of three day prior hospitalization would accomplish.

Last year Congress eliminated this requirement for home health services. S.1754 introduced by Senator Heinz last September would do the same for skilled nursing facilities.

As early as 1976 an HHS report, Forward Plan for Health, endorsed elimination of the three-day stay stating, " . . . experience suggests that significant numbers of Medicare beneficiaries now receiving hospital care would benefit as much from SNF care . . ." and " . . . it is probable that patients in need of only skilled nursing care, and who are now instead hospitalized are never subsequently transferred to an SNF because of paperwork (eg, transfer of medical records, treatment plan) and the lack of any financial incentive or disincentives (eg, no cost sharing is required after first hospital day and until the 61st day)."

In discussing potential savings, the Forward Plan for Health goes on to say, "since the average Medicare cost of a covered day in an SNF is less than one-third the routine cost per day in a hospital, the potential cost savings is obvious".

Much has happened in the intervening six years since HEW made that recommendation. Most notable is that hospital costs have now escalated to $200 to $400 per day. While the average Medicare SNF rate was $45.36 last year. It goes without saying that keeping any patients out of hospitals who don't need to be there would save millions of dollars.

Physicians freely admit that they place their patients in hospitals solely to qualify them for the Medicare SNF benefit. Many of these patients never find their way to the nursing home because a bed might not be available, or because they help a sagging hospital utilization rate and are never discharged into the appropriate level of care.

A four-year demonstration project in Massachusetts and Oregon which permitted direct entry into a nursing home of Medicare-eligible skilled nursing patients found cost savings in avoided hospitalization and identified a number of other potential indirect cost savings. These included fewer physician visits (physicians are reimbursed at a higher rate for their hospital patients versus nursing home patients) and lower ancillary services cost and utilization.

In evaluating the study results Abt Associates found a net potential savings of $3 million in eliminating the three-day stay requirement--an increase in Medicare SNF costs of $46 million and a savings of $49 million in reduced hospitalization. It should be noted that this evaluation was extremely conservative in deriving estimates and this was so stated in the report. Further, none of the potential indirect savings mentioned above were included, nor was there any consideration of those patients who enter hospitals in order to qualify, but who never are discharged, staying in the hospital until the termination of their illness.

The Abt study found that many patients who entered the nursing home directly under the waiver, were terminal cancer patients, those for whom heroic and costly life saving treatments are unnecessary. Other patients were at an intermediate care level and became more ill, making them eligible for Medicare. These patients would routinely have entered the hospital in order to qualify.

We should point out that the Health Care Financing Administration has refused to accept the results of the Abt study and discounts any potential savings because, according to HCFA, an empty hospital bed would be paid for anyway under Medicare's cost reimbursement system.

In our opinion, this only serves to point out the ludicrous nature of Medicare's reimbursement system, not the validity of the study's results. To imply that a hospital bed would be paid for by Medicare whether it is empty or not would seem to indicate a casual attitude towards restraining medical care costs that is certainly contrary to the expressed concerns of the President and the Secretary. We do not believe this is the case.

To those who have expressed concern over the potential for increased SNF utilization, we would propose the imposition of a high deductible, such as 50% of the hospital deductible to act as a barrier to unnecessary utilization. This amount would actually cover the cost to Medicare of the first three days in the SNF.

Prospective Reimbursement

Much of the dissatisfaction nursing homes have with the Medicare program can be traced to its retrospective system of reimbursement.

The complexity of retrospective reimbursement and its cost reporting requirements has forced nursing homes to hire CPA's with Medicare experience just in order to remain in the program. It is also the reason that many smaller homes and single facilities have been dropping out. When so few patients meet the Medicare eligibility requirements and then for only a few days' time, it is simply not worth the extra effort involved to maintain Medicare certification.

The case against Medicare's retrospective reimbursement is almost overwhelming. It is cost inflationary, provides no incentives for efficiency, nor for containing costs. Perversly, it rewards the inefficient provider: those who spend more, get more. At the same time, costs accepted as legitimate business expenses in all other sectors of our economy are not recognized by Medicare. Further its system of allocating portions of costs to various cost reporting centers is inappropriate and unnecessarily complex in the context of a nursing home.

In discussing the disadvantages of retrospective reimbursement, a study by the Battelle Institute notes, "The more complicated the system, the more likely the system will be unenforceable. Every additional cost item reviewed, audited, or monitored represents a further dilution of monitoring resources, and each additional regulation requires additional effort to assure compliance by the industry". This description fits the Medicare payment system perfectly. The Battelle study futher states, "Rather than trying to monitor and control the behavior of 18,000 individual nursing homes, attention should be directed to the design of a payment system for nursing home services in which incentives for the efficient use of resources are built into the system. There would then be no need for expensive if not impossible monitoring and control of the nursing home industry".

We endorse this recommendation wholeheartedly and believe that a prospective payment system fulfills these requirements perfectly.

The fact that 38 states already reimburse prospectively for Medicaid nursing home services should be a strong incentive for doing the same for Medicare. It is both illogical and inefficient to have two separate payment methodologies in effect in a 100 or 150 bed nursing home. Medicare's disallowances, non-covered costs, ceilings, and retroactive denials are disincentives which have nevertheless failed to restrain costs.

Various proposals for prospective reimbursement are being discussed and we welcome the dialogue. Many of the problems of Medicare--paperwork, complexity, inflationary aspects, could be eliminated simply by implementing prospective reimbursement. We are encouraged that the Administration and members of Congress are now giving this issue important consideration. We stand ready to assist in that effort.

MEDICAID

Three Percent Reduction in Match

For the majority of nursing home patients, Medicaid is the principle source of payment for their benefits. While we understand that many of the Administration's proposals are not cuts but rather reductions in the rate of spending, we wish to point out that with regard to the 3% reductions this is not necessarily the case. No matter how much states may have reduced their Medicaid expenditures, these proposals penalize all.

The proposal which would reduce by three percentage points federal matching rates for optional services for the categorically needy and for all services for optional groups, including the medically needy, would cut federal Medicaid expenditures for FY 83 by $600 million.

The term "optional" with regard to these services and beneficiaries is to some extent misleading, for they are neither frivolous nor luxury items. The majority of Medicaid eligible nursing home patients are classified as medically needy; patients in intermediate care facilities (ICF's) comprise the primary optional service. In 1979, nearly 61% of the Medicaid payments in these two areas were for long term care services.

We feel compelled to point out that these two reductions, in addition to the 4% reduction in federal Medicaid payments mandated last year by Congress, would concentrate inequitably on one specific beneficiary population: elderly nursing home patients on Medicaid.

The attached chart, prepared by the Congressional Research Service shows the extent of the impact of these two reductions on states in FY 83.

As pointed out earlier, the uncertainties and apprehensions that attend the budget making process each year, whereby each group of beneficiaries and providers receives smaller and smaller pieces of the same pie, or none at all, mandate significant changes in the structure of that system, rather than a continuation of the old one. One major element of that change would be the federalization of Medicaid.

Medicaid Co-Payments

The Administration's FY 83 budget proposal includes a provision requiring nominal copayments on a variety of health services. These include a $1 per visit copayment on the categorically needy and a $1.50 per visit copayment on the medically needy for physician, clinic and hospital outpatient department services. In addition, a $1 and $2 copayment per day would be required of the categorically and medically needy respectively, for inpatient hospital services.

We support the concept of cost-sharing and believe that these modest amounts should not impose undue hardships on beneficiaries. At the same time, we believe that by participating in the expenses of their health care, rather than receiving it cost-free, will serve to make Medicaid recipients more cost-conscious and perhaps act as somewhat of a barrier to unnecessary utilization or over-utilization.

Supplementation

Included in the FY 83 budget are plans for proposed regulations to allow states, under their laws of general applicability, to require adult children of institutionalized Medicaid recipients to contribute to the cost of their parents' care.

The National Council has previously endorsed the concept of shared responsibility through private supplemental payments for the cost of Medicaid patients' nursing home care.

We believe that states, patients, and their families should have that flexibility, given the shortages being experienced in state Medicaid funds. At the same time, families have expressed a desire to contribute a nominal amount for their elderly relatives' care. An added positive benefit would be the involvement of those families in purchasing nursing home services and in assuring that quality care is delivered.

It should be noted that numerous states have been moving in this direction, by requesting necessary waivers from the Health Care Financing Administration and by seeking federal and state legislation. As an example of the extent family supplementation can alleviate a portion of the Medicaid burden, in 1976 when the federal government ended the practice of allowing supplementation, Tennessee's intermediate care facility budget increased by 28%. Relatives of nursing home patients as well as friends, churches, philanthropic groups, and counties had been allowed to contribute funds to the facility to supplement the state's basic rate for Medicaid care.

We feel strongly that this option must be available to states in order to avoid possible cutbacks in staffing and services to nursing home patients.

Federalization of Medicaid

President Reagan has proposed what has been called a major "swap" of federal and state programs. One component of that swap is the full assumption of the Medicaid program by the federal government beginning in FY 84.

The Board of Directors of the National Council of Health Centers has given its endorsement of the President's proposal with the caveat that it not be modeled after the Medicare program's overly complex payment system and administrative structure. We would also predicate our support upon the ability of the states and the federal government to reach an agreement as to which services are to be assumed by the federal government and at what level of expenditure as well as a uniform eligibility standard.

In conjunction with the federalization of Medicaid, we urge consideration of the steps necessary to establish a national policy for long term care. It is appropriate that these two actions be taken simultaneously and that they are entirely compatible. We feel that the impending fiscal crisis in the Social Security Trust funds, as well as that already being experienced in Medicaid, force some drastic and far-reaching changes to be made.

As mentioned earlier, we feel it is vital to restructure the financial supports of long term care into a more pluralistic system in which competition would play a key role. To this end, we strongly support the adoption of the principles of competition in that system and the incorporation of the same competitive purchasing practices for Medicare and Medicaid beneficiaries as presently exist for private patients seeking nursing home care. There are a number of ways of instilling competition at the Medicare/Medicaid consumer's point of purchase, such as the use of vouchers.

Further in seeking alternative funding mechanisms we should consider the many imaginative proposals available such as:

- Tax incentives to encourage the development of private insurance plans for long term care, including coverage of supplemental payments and coinsurance premiums.

- Inheritance tax policies which recognize individuals' financial commitments and responsibilities in providing for the care of their elderly family members in their homes and appropriate health centers.
- Establishment of self-help programs such as subsidized reverse mortgages in which individuals could borrow on the equity in their residence to assist in the payment for their long term health care costs.
- Taxing programs with revenues being totally dedicated to long term health care for the elderly such as excise taxes on liquor and cigarettes.
- Tax credits recognizing the fees of condominiums dedicated to congregate living under life health care plans.
- Allow tax credits for increased contributions to IRAs, KEOGHs, and pension funds if they are dedicated for the support and payment of long term care after the individual reaches the age of retirement.

Conclusion

The Administration has had to make some difficult decisions with regard to its fiscal year 1983 budget proposals. No segment of the Medicare/Medicaid provider and beneficiary population will remain untouched or unaffected by the changes and some of these cuts will result in hardships.

President Reagan has recognized that this process cannot continue, and so has set in motion discussions and proposals for sweeping changes in the Medicare and Medicaid programs. The National Council believes that the debate on these changes is an appropriate opportunity as well for discussion of some necessary fundamental changes in our long term care system. We urge its inclusion on the debate.

TABLE 3

PRELIMINARY ESTIMATE OF IMPACT OF FY 1983 ADMINISTRATION MEDICAID PROPOSAL ON FEDERAL MEDICAID REIMBURSEMENT TO STATES.
(ADMINISTRATION PROPOSAL WOULD REDUCE THE FEDERAL MATCHING RATE BY THREE PERCENTAGE POINTS FOR ALL SERVICES PROVIDED TO NON CASH WELFARE RECIPIENTS AND FOR OPTIONAL SERVICES PROVIDED TO CASH WELFARE RECIPIENTS.

(DOLLARS ARE IN THOUSANDS)

STATE	STATE ESTIMATE OF FY 1983 FEDERAL PAYMENTS (NOV. 1981)	FEDERAL PAYMENTS AFTER 3 PERCENTAGE POINT REDUCTION	LOSS FROM REDUCTION	4 PERCENT P.L. 97-35 REDUCTION	COMBINED LOSS FROM BOTH REDUCTIONS (EXCLUDED REBATES)
ALABAMA	281,656	275,319	¯6,337	264,306	¯17,350
ALASKA	31,843	31,325	¯518	30,072	¯1,771
ARIZONA					
ARKANSAS	258,195	252,286	¯5,909	242,195	¯16,000
CALIFORNIA	2,326,017	2,259,410	¯66,607	2,169,034	¯156,983
COLORADO	154,335	150,713	¯3,622	144,684	¯9,651
CONNECTICUT	252,021	241,662	¯10,359	234,412	¯17,609
DELAWARE	35,310	34,244	¯1,066	32,874	¯2,436
DIST. OF COL.	118,365	114,724	¯3,641	110,135	¯8,230
FLORIDA	405,206	395,891	¯9,315	380,055	¯25,151
GEORGIA	465,211	453,431	¯11,780	435,294	¯29,917
HAWAII	80,974	78,506	¯2,468	75,366	¯5,608
IDAHO	50,540	49,039	¯1,501	47,077	¯3,463
ILLINOIS	839,850	808,795	¯31,055	776,443	¯63,407
INDIANA	360,622	350,899	¯9,723	336,863	¯23,759
IOWA	183,668	177,721	¯5,947	170,612	¯13,056
KANSAS	137,527	131,686	¯5,841	126,419	¯11,108
KENTUCKY	323,674	316,414	¯7,260	303,757	¯19,917
LOUISIANA	467,621	457,639	¯9,982	439,333	¯28,288
MAINE	156,330	153,124	¯3,206	146,999	¯9,331
MARYLAND	313,301	305,365	¯7,936	296,204	¯17,097
MASSACHUSETTS	732,906	706,114	¯26,792	684,931	¯47,975
MICHIGAN	853,031	827,345	¯25,686	802,525	¯50,506
MINNESOTA	505,634	489,272	¯16,362	469,701	¯35,933
MISSISSIPPI	268,383	263,088	¯5,295	252,564	¯15,819
MISSOURI	331,016	322,966	¯8,050	310,047	¯20,969
MONTANA	64,504	62,784	¯1,720	60,273	¯4,231
NEBRASKA	94,127	91,302	¯2,825	87,650	¯6,477
NEVADA	53,042	51,892	¯1,150	49,816	¯3,226
NEW HAMPSHIRE	66,382	64,231	¯2,151	61,662	¯4,720
NEW JERSEY	544,017	524,713	¯19,304	508,972	¯35,045
NEW MEXICO	90,432	88,852	¯1,580	85,298	¯5,134
NEW YORK	3,670,699	3,545,639	¯125,060	3,439,270	¯231,429
NORTH CAROLINA	461,293	451,025	¯10,268	432,984	¯28,309
NORTH DAKOTA	56,203	54,908	¯1,295	52,712	¯3,491
OHIO	797,944	777,680	¯20,264	746,573	¯51,371
OKLAHOMA	272,929	265,855	¯7,074	255,221	¯17,708
OREGON	126,136	121,188	¯4,948	116,340	¯9,796
PENNSYLVANIA	1,107,875	1,080,672	¯27,203	1,037,445	¯70,430
RHODE ISLAND	123,721	119,347	¯4,374	115,767	¯7,954
SOUTH CAROLINA	244,151	237,509	¯6,642	228,009	¯16,142
SOUTH DAKOTA	55,159	53,718	¯1,441	51,569	¯3,590
TENNESSEE	462,193	452,745	¯9,448	434,635	¯27,558
TEXAS	880,136	855,533	¯24,603	821,312	¯58,824
UTAH	90,896	88,791	¯2,105	85,239	¯5,657
VERMONT	60,695	59,150	¯1,545	56,784	¯3,911
VIRGINIA	303,925	294,772	¯9,153	282,981	¯20,944
WASHINGTON	241,048	232,514	¯8,534	225,539	¯15,509
WEST VIRGINIA	117,466	115,231	¯2,235	110,622	¯6,844
WISCONSIN	694,239	675,811	¯18,428	648,779	¯45,460
WYOMING	13,637	13,249	¯388	12,719	¯918
TOTALS	20,626,085	20,026,089	¯599,996	19,290,073	¯1,336,012

TABLE PREPARED BY CRS. ESTIMATES ARE SUBJECT TO LIMITATIONS OF DATA AND THE ASSUMPTIONS USED IN ESTIMATION. DETAIL MAY NOT SUM TO TOTALS DUE TO ROUNDING

NOTE: BASIC DATA PROVIDED BY HEALTH CARE FINANCING ADMINISTRATION. TOTAL IMPACT OF THREE PERCENTAGE POINT REDUCTION IS ESTIMATED AT 600 MILLION DOLLARS IN FY 1983 BY THE ADMINISTRATION. THIS TOTAL WAS DISTRIBUTED ACROSS STATES ON THE BASIS OF CALCULATIONS DONE ON FY 1980 DATA

The **Chairman**. We will adjourn until 9 tomorrow morning.

[Whereupon, at 11 a.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF
MICHAEL D. BROMBERG
EXECUTIVE DIRECTOR
FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman, the Federation of American Hospitals appreciates this opportunity to present our views to the Committee on small issue industrial development bonds (IDBs) and the financing of hospitals and other health care facilities.

The Federation of American Hospitals is the trade association for the approximately 1000 investor-owned hospitals and hospital management companies. Very few of these investor-owned hospitals were built with IDB financing due to the fact that a $10 million ceiling applies to projects involving small issues used in connection with for-profit health institutions. Those few hospital projects which have used small issue bond financing involve small hospitals or expansions in rural communities.

The Administration's proposals to curb the use of tax-exempt bond financing in general, and small issue IDBs in particular, have focused attention on users such as nightclubs, fast food establishments, and retail or commercial operations which some felt were not contemplated by Congress. Little attention has been focused on the contribution of this form of financing to health care services in economically marginal areas of the country where other forms of financing are not available.

Only about one percent of tax exempt financing for hospitals involves small issue IDBs for investor-owned hospitals. Over the past decade we estimate that fewer than fifty investor-owned hospitals have been built with IDBs but these facilities are located in areas of clear need and many represent sole community providers.

Without IDB financing, such communities would often have no choice but to take on the burden of providing needed health care services directly through a community owned and operated facility financed by public or not-for-profit authorities. Because of the increased complexity and escalating cost of hospital operations, however, communities have been withdrawing from such direct service delivery commitments and turning increasingly to investor-owned systems which have the managerial capacity and operational efficiencies to maintain and improve health care quality.

The need for all types of health care capital financing will be even greater over the next decade. Conservative estimates place capital needs in the 1980s at $190 billion for essential hospital replacement alone. In addition, this country has a major existing shortfall in nursing home beds which will increase substantially as the number of elderly as a percentage of the population increases. An estimated $10.6 billion in capital will be necessary to construct the 260,000 long term care beds needed by 1990. Small issue IDB financing will be a critical function in many communities caring for their elderly.

Having described the importance of small issue IDB financing is not to suggest that reforms in the program are not necessary. It is clear that abuses have occurred and must be prevented from re-occurring in the future. Restricting access to IDBs for enterprises which are not clearly in the public interest such as nightclubs are certainly justified. Requiring public hearings and reporting of information on IDB use are also in the public interest. We believe that these and other improvements in the program can be made without having to resort to eliminating the program where it has demonstrated its value to communities throughout this country.

The Administration's proposal to eliminate big business use of IDBs is arguably irrelevant and discriminatory in this context. If the IDB serves a valid public purpose, then the size of the company should not be consequential.

Finally, it is important and relevant to vote the impact on the Medicare budget of any move to eliminate health facility IDB financing. If small issue financing is unavailable and if commercial financing is utilized, debt service costs will increase substantially in those health facilities. Health care costs will rise in general and Medicare cost reimbursement for higher interest payments will increase Medicare trust fund expenditures in particular.

Sound public policy for providing access to health facilities in rural and economically depressed areas and sound federal budget policy for containing Medicare expenditures lead us to conclude that health facilities should be exempt from the proposed elimination or restrictions on small issue IDBs.

HEALTH CARE FINANCING STUDY GROUP

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STATEMENT OF THE HEALTH CARE FINANCING STUDY GROUP ON PROPOSALS TO INCREASE TAX REVENUES

Submitted to
The Senate Finance Committee

April 2, 1982

The Health Care Financing Study Group (HCFSG) is an informal association of investment banking and other professional service firms which are involved in underwriting long-term financings for health care facilities. The members of the Group handle the vast majority of long-term debt financing for health care institutions in America today.

The HCFSG is deeply concerned over the impact which the Administration's legislative proposals will have on the use of long-term tax-exempt debt by nonprofit, charitable hospitals. In brief, the position of the HCFSG is this: As they would apply to nonprofit hospitals, the Administration's proposals are unnecessary and they are expensive. They fail the fundamental cost-benefit test to which any legislative proposal should be subjected.

We have heard it argued that additional requirements are needed in order to assure that so-called "private purpose" tax-exempt bonds in fact serve a public purpose. Yet the public purpose of nonprofit hospitals' use of tax-exempt bonds is already more than adequately guaranteed in several different ways. First, each of these hospitals is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. This *a priori* tax-exempt status is strong evidence that the hospital, and its normal capital development needs, serve a public purpose. Second, the nationwide health planning system assures that each hospital construction project serves a public purpose. Each hospital construction project must go through a lengthy process of public hearing, review, and approval at both the local and state level, before a certificate-of-need (CON) is granted. By law, a CON will not be granted unless the construction project is needed and serves a public purpose. It is a practical impossibility to secure private sector capital financing on any basis for a hospital without a CON.

Third, in most bond-issuing jurisdictions, and especially in those states that have hospital financing authorities, there is no authority to issue tax-exempt hospital bonds without a prior finding that their use will serve a public purpose.

Some have argued that restrictions on tax-exempt bonds are needed to curb runaway hospital construction. Yet, the trend lines in hospital construction and hospital tax-exempt financing have been moving in opposite directions for the last decade. In constant dollars during the years 1971 to 1979, hospital construction fell 35 percent, from $2.9 billion to $1.9 billion. During those same years, hospitals' use of tax-exempt bonds grew over 600 percent from $.2 billion to $1.4 billion. If tax-exempt bonds somehow "fuel" hospital construction, we would expect to see both rising simultaneously. Yet, we see just the opposite. There is no causal link between the availability of tax-exempt bonds and hospital construction starts.

The proposed restrictions will be expensive. Each part of the Administration's proposal will place a new requirement on hospital tax-exempt financing. Each will add another step to the process of getting to market, and each will carry a pricetag. For some of these additional steps, the pricetag will be relativelyminor. For others, the price will be high.

At the margin, these added costs will be just enough to push hard-pressed hospitals out of the market altogether. These hospitals, which are close to the financial margin in the best of times, are not evenly distributed throughout the socio-economic spectrum of our country. They are mainly to be found in inner-cities and economically distressed areas where they form the principal, and often the only, means of health care delivery for their disadvantaged patient population.

Let us look at three of these additional requirements which are part of the Administration's proposal: the local approval requirement, the local contribution requirement, and the lowered arbitrage restrictions. Perhaps enough has already been said to establish the redundancy of approval by local elected officials. By the time a hospital project has been approved by two layers of the health planning process, and has been subject to public hearings as part of that process, the need for a local approval requirement has been met.

The local contribution requirement causes us grave concern because it cannot be fairly applied to charitable hospitals, at least as originally proposed by the Department of Treasury. One of the principal ways for meeting this requirement would be an express decision to forgive state and local taxes which could otherwise apply to the facility being constructed with tax-exempt bonds. For nonprofit hospitals, this option makes no sense because they have a pre-existing abatement of state and local taxes which grows out of their charitable status. There is some reason to believe that the Administration has recognized that a general, pre-existing abatement of state and local taxes should be sufficient to meet this local contribution requirement, at least for 501(c)(3) charitable institutions which use tax-exempt bonds. We strongly urge this Committee, at a minimum, to make certain that this understanding of the local contribution requirement, as applied to nonprofit hospitals, becomes part of any tax-exempt bond legislation which is passed.

Finally, let us turn to the arbitrage restrictions, whose costs are least obvious, but most alarming. We calculate that the arbitrage restrictions will force hospital tax-exempt bond issues to be "up-sized" by 2 to 4 percent before going to market. While this level of increase may seem modest, it becomes more serious when we look at the consequent increase in debt service cost over the normal thirty-year payback period, especially at today's historically high interest rates. The arbitrage restrictions will increase the total principal and interest payments over the thirty-year period by an amount which is equal to 15 to 20 percent of the initial bond issuance. We can illustrate this effect with a hypothetical $100 million hospital bond issue. If the new arbitrage restrictions are allowed to go into effect, there will be an additional $15 to $20 million in payback costs over the life of the loan. The vast bulk of that increase will be in the form of interest payments. We hardly need point out to this Committee that the federal government will suffer a major share of this cost increase since interest is a reimbursable item under Medicare and Medicaid.

To reiterate, the proposals to place new requirements on the use of tax-exempt financing for private activities, however laudable their intent, are unnecessary when applied to nonprofit hospitals. Further, they will prove to be very expensive. At the margin, they will mean that certain hospitals, which are vitally needed by their communities, will be barred from access to the private capital market.

CALIFORNIA ASSOCIATION OF CHILDREN'S HOSPITALS

Submitted by

Blair Sadler
President
California Association of Children's Hospitals

I am Blair Sadler, President of Children's Hospital and Health Center, San Diego, and President of the California Association of Children's Hospitals (CACH). CACH was founded to promote adequate recognition of the special needs and circumstances of children's hospitals in the formulation of public health care policy. The Association is composed of Children's Hospital Medical Center of Northern California, Oakland; Children's Hospital of Orange County; Children's Hospital at Stanford; Children's Hospital and Health Center, San Diego; Valley Children's Hospital and Guidance Clinic, Fresno; Earl and Loraine Miller Children's Hospital Medical Center, Long Beach; and Children's Hospital of Los Angeles.

These hospitals provide the vast majority of all tertiary and many of the secondary health care services to children in the State of California. As documented in a recent study by the National Association of Children's Hospitals and Related Institutions, children's hospitals operate at a higher cost than general hospitals because of the type and intensity of care required for their patient population -- care which permits children who would have died a decade ago to survive today and live completely normal and productive lives. For example, children's hospitals maintain more specialized services, such as neonatal care, developmental disabilities, and family counseling, and devote a greater percentage of beds and days of hospitalization to intensive care than general hospitals. Also, quite simply, children require substantially more attention by health professionals than other patient populations.

In addition to the specialized intensive care provided to their patients, children's hospitals serve a proportionately greater number of indigent children. On the average, children's hospitals deliver a significantly higher percentage of non-compensated (free) care -- averaging about 17 percent of total gross charges -- than general hospitals. In addition, within each of our children's hospitals, Medicaid beneficiaries represent from one-third to over one-half of all patients served. Clearly, children's hospitals are heavily dependent on public revenues to support their health care facilities.

From this unique perspective, CACH would like to take this opportunity to comment on the Administration's Fiscal Year 1983 budget proposals for child health care. Specifically, we would like to share our concerns over the proposed budget cuts and legislative changes in the Medicaid program and the Maternal and Child Health block grant.

MEDICAID, TITLE XIX OF THE SOCIAL SECURITY ACT

The Administration is proposing to cut $2.1 billion from federal Medicaid outlays in FY 1983. This amount is in addition to the $944 million in reductions authorized for FY 1982 as well as the $880 million cutback in federal matching payments scheduled for implementation in 1983 under the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). If the further proposed reductions in federal funds for the Medicaid program are approved by Congress, the combined FY 1982 and FY 1983 cuts would total nearly $4 billion.

In these difficult economic times, when many states like California are experiencing severe reductions in their own revenues, the proposed cutback in federal Medicaid outlays would add to an already staggering financial burden. States would be forced to limit severely or to eliminate completely medical services previously covered under their Medicaid plans. Hospitals would be faced with the choice of providing even higher levels of non-compensated care or cutting back on previously provided services. Ultimately, the 22 million low-income aged, blind, and disabled persons, and mothers and medically needy families with dependent children, who rely on the Medicaid entitlement program, would suffer from the added financial burdens as well as the inability to obtain necessary health care services.

For the 11 million children whose sole means of financing checkups, medical treatment, dental care, hospitalization, and necessary medication is Medicaid and for the children's hospitals which serve a disproportionately high percentage of Medicaid beneficiaries, last year's federal cutbacks already have had serious repercussions. In response to the FY 1982 federal budget reductions, California imposed a 6 percent maximum on the rate of increase for inpatient hospital reimbursement under the Medi-Cal plan.*/ This provision included no means for taking into account the special needs of high Medicaid providers, like children's hospitals, as stipulated by the 1981 Budget Act.

As a result of this 6 percent "cap", the Children's Hospital Medical Center of Oakland, California faced a serious decrease in available revenue. With over half of its patients Medi-Cal recipients, the hospital argued to the federal Health Care Financing Administration that the California plan ignored the disproportionate number of low-income patients served by the hospital which, under the "cap", would suffer approximately $1.7 million in revenue losses. While the state adjusted the hospital's "cap" to 13 percent, this limited reprieve still required the hospital to reduce its operating budget extensively. This cutback, in turn, resulted in widespread, permanent lay-offs of full-time employees.

Of graver consequence to the hospital will be implementation of the state's FY 1983 proposal to reduce the current $5 billion Medi-Cal budget by $0.5 billion. In effect, the cutback will total $1 billion -- including $0.5 billion from the federal matching share -- or 20 percent of the current budget. Slated for implementation in July, 1982, this proposal does not even reflect further reductions proposed in the federal Medicaid program for FY 1983.

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*/ Medi-Cal is the plan operated by the State of California as the state counterpart to the federal Medicaid program.

In an attempt to address the state's FY 1983 budget cuts, Oakland Children's Hospital anticipates making further reductions in staff as well as substantial cutbacks in outpatient services provided to indigent individuals. Currently under consideration is the elimination of certain community-oriented programs such as child psychiatric services, family guidance counseling, adolescent health care, and family planning services. Additionally, the hospital is considering the feasibility of establishing a dual standard of care -- one for private patients and one for Medi-Cal patients.

Another, more controversial option concerns a new credit policy whereby a patient must possess a valid Medi-Cal or Blue Cross/Blue Shield card or pay cash before the hospital will treat a patient. Operating on a "bare bones" budget at present, the hospital tentatively is considering to refuse ambulatory treatment to indigent patients who cannot pay for their health care services.

Clearly, the proposed reductions in Medi-Cal payments for FY 1983 will have a devastating effect on the availability and quality of health care services to be provided by Oakland

Children's Hospital. However, a further concern is that the hospital may face the possibility of financial insolvency. Any significant decrease in its current revenues could force the hospital to default on the state-insured bonds used to finance hospital projects. In this respect, Oakland Children's Hospital is not an isolated example.

At present, the hospital's inpatient rates for private patients already are marked up 50 percent to cover a $2 million loss from outpatient services, inpatient services for indigent patients, shortfalls in the Medi-Cal program, and bad debts. To offset the proposed reductions in Medi-Cal payments, the hospital could cost shift further, and raise the private patient rates. However, if the rates increase, the private patients will go to other hospitals or clinics to receive treatment. This shrinking of the private patient base, in turn, will exacerbate the problem by forcing the hospital to become even more dependent upon the Medi-Cal program. Simply put, very little opportunity exists for the hospital to shift costs to other sources.

Of course, the real impact of the Administration's proposed budget reductions for Medicaid would be seen not in its effects on one children's hospital but from the cumulative effect that these cuts would have on the health of this nation's children.

Hospitals increasingly would be forced to terminate crucial health care services and to undercut the quality of these services. If further cutbacks in Medicaid are approved by Congress, this tragic scenario would become a reality for many of our children's hospitals.

With this background in mind, we would like to direct the Committee's attention to several of the legislative changes recommended by the Administration to achieve the $2.1 billion "savings".

Copayments

The Administration is proposing to require states to impose copayments on categorically needy beneficiaries as well as on all medically needy mothers and children. Under this proposal, the former category of beneficiaries would pay $1 for each day of hospitalization and $1 for each visit to a clinic, physician's office, or emergency room; the latter class of beneficiaries would pay $2 per day for hospitalization and $1.50 for each outpatient visit.

By mandating copayments for Medicaid recipients, the Administration would impose a further economic burden on individuals who, after last year's alterations in Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) eligibility requirements, are truly financially disadvantaged. Contrary to the Administration's contention that cost-sharing would discourage the unnecessary utilization of health care services, this proposal would discourage individuals from seeking necessary treatment and, ultimately, contribute to higher health care costs.

For children's hospitals, the expense of collecting on the provided service would add to the already existing non-reimbursable costs for unpaid health care services. Clearly, the added financial cost of copayments would result in many needy families not being able to afford the fee. Yet, hospitals would be forced to attempt collection, and, where families are unable to pay the fee, absorb the additional cost of providing the health care at no charge.

Added to the high ratio of free care currently being provided at our children's hospitals, this expense would serve only to aggravate the problems associated with further cost shifting to private patients. As noted above, cost shifting is of particular concern to high Medi-Cal providers because, at some point, these hospitals would be unable to compete for the private patients due to these high rates. In addition, cost shifting poses problems for the private insurance industry, as the inflated rates become a type of subsidization for government program patients.

The end result of this proposal would be to place our hospitals in the position of refusing health care services to indigent patients. As noted above, Oakland Children's Hospital already is facing this dilemma for the upcoming summer. If a hospital cannot afford to maintain the level of free care provided to its indigent patient population, the hospital simply would have to refuse service at the outset. Otherwise, some children's hospitals would not be able to continue in operation, even for those patients able to pay for their health care expenses.

Eligibility

Two further proposals by the Administration would (1) place certain restrictions on AFDC and SSI eligibility standards to reduce the number of categorically needy recipients by 133,000, and (2) shorten the automatic extension of Medicaid eligibility from four months to one month for individuals who lose their status as recipients of cash assistance from the AFDC program. As a result of changes authorized by the 1981 Budget Act, approximately 1.1 million Medicaid recipients will be removed from the rolls in 1983. About 181,000 of those losing eligibility will be adults in AFDC families. Another 661,000 will be children under 21 years of age. The Administration's FY 1983 changes would limit further the individuals eligible for Medicaid assistance.

Both proposals would serve to undermine the efforts of families to be self-sustaining. In order to remain eligible for AFDC assistance and to retain their Medicaid status, individuals would be discouraged from earning monthly wages. These proposals would serve only to swell the already burgeoning ranks of the unemployed.

For hospitals, these proposals would complicate reimbursement schedules for patients who may begin receiving treatment as Medicaid recipients, who later may lose their beneficiary status, and who, a few months later, may become eligible for Medicaid by virtue of being unemployed once again. Particularly where a child's illness may require extensive hospital care, the one-month "grace" period would not offer a suitable amount of time for proper treatment. Again, children's hospitals would be faced with providing increasingly high levels of non-reimbursable care. Concurrently, the financial integrity of the hospitals would be undermined.

Optional Services

Included in the FY 1983 budget is a proposal to reduce the federal matching rate by 3 percent for "optional" services (e.g., intermediate care facility services, prescription drugs, eyeglasses, dental care, clinic services, physical therapy, occupational therapy, and speech and hearing therapy) provided to categorically needy beneficiaries and for services provided, at the state's option, to all medically needy families. While the Administration appears to be reconsidering this proposal, CACH would like to comment on the adverse impact it would have on children's hospitals.

Although a state now may provide categorically needy recipients with certain "optional" services as well as maintain a medically needy plan, the proposed cutback would force states to reduce drastically or to discontinue completely these services to Medicaid beneficiaries. And yet, in terms of need, these "optional" services may be absolutely necessary for poor mothers and children. For example, receiving prenatal care from a neighborhood clinic is not "optional" for a pregnant mother. This care is absolutely essential to prevent more costly complications at the time of delivery and for the mother's unborn child. For a diabetic child, getting an insulin prescription is not "optional". And, for a handicapped child who can walk only with the aid of braces, getting the braces is not "optional". These services are absolutely necessary for the health of these children.

For children's hospitals, the potential elimination of "optional" services covered under a state's plan or the potential discontinuation of a state's medically needy program would pose severe financial hardships. As noted above, children's hospitals no longer can cost shift to private patient revenues. If the hospitals attempt to absorb these additional cutbacks in Medicaid funding, and continue to maintain a high ratio of free care, the result would be a disastrous shortfall in available revenue for the hospitals' operations. Financial insolvency would be the sure consequence of these further budget reductions.

MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT, TITLE V OF THE SOCIAL SECURITY ACT

Since 1935, the Maternal and Child Health and Crippled Children's Services programs -- authorized originally by Title V of the Social Security Act -- have been the major federal health initiative aimed specifically at needy mothers, infants, and handicapped children. In 1980, alone, nearly 15 million poor mothers, infants, and children received services ranging from basic prenatal care for mothers and immunizations for children to the most sophisticated medical treatment for crippled children and intensive care for newborn infants. Emphasizing prevention, early detection, and specialized treatment, these programs have been successful over the last 45 years in reducing infant mortality, decreasing the incidence of mental retardation, treating crippled children, and improving the overall health of mothers and children.

Through the Maternal and Child Health (MCH) block grant established by the 1981 Budget Act, this national commitment to improve child health has been promoted through a streamlined partnership between the federal and state governments. States have been afforded greater authority to address their own particular needs in the coordination of the Maternal and Child Health and Crippled Children's program; the Supplemental Security Income Program for Disabled Children; the Lead-based Paint Poisoning Prevention program; the Voluntary Testing and Counseling Programs for Genetic Diseases; the Sudden Infant Death Syndrome program; the Hemophilia Diagnosis and Treatment Centers program; and the Adolescent Pregnancy program.

However, the FY 1982 appropriations level of $347.5 million, as included in the current Continuing Resolution, represents a 24 percent reduction from the FY 1981 appropriations for these programs. For states, this cutback has meant that fewer maternal and child health projects have been financed this year. Across the country, children's clinics have been closed, crippled children's services have been reduced, family planning programs have been eliminated, and fewer staff have been employed to manage quality and cost-effective MCH projects.

For organizations like children's hospitals, the consolidation of more programs within the MCH block grant at a reduced funding level has meant greater competition among more interest groups for fewer dollars. Some of the projects affected by this cutback are those funded through the California Children's Service centers located within the children's hospitals. These programs include treatment for children with cardiac problems, congenital spine and other crippling diseases, genetic disorders, endocrine metabolic diseases, hemophilia, and cystic fibrosis.

For the FY 1983 budget, the Administration is proposing to merge two additional programs -- the Special Supplemental Food program for Women, Infants, and Children (WIC) and the Commodity Supplemental Foods Program (CSFP) -- into the Maternal and Child Health (MCH) block grant. Without any adjustment for inflation, the Administration's proposed FY 1983 authorization for this new block grant at $1 billion would represent a further reduction of 22 percent from the FY 1982 appropriations levels for all three programs.

First and foremost, CACH believes that no sound basis exists for merging a nutrition program with a health services program. Each program serves a separate, distinct function subject to different administrative requirements. For this reason, we believe each program should maintain a separate fiscal identity.

Second, this Congress must be aware that the proposed cutback in federal funds would result in a substantial reduction in maternal and child health care services. Faced with an increasing reduction in federal assistance for various programs, states would not be able to compensate for this further cut in federal outlays for the new MCH block grant. For our children's hospitals, an additional reduction in funds for MCH grants would mean that many handicapped children would not receive needed hospitalization and surgical care. Moreover, the gains achieved over the past 45 years in reducing mental retardation and infant mortality rates would be eroded due to unavoidable cutbacks in prenatal services and intensive care for infants. Ultimately, the target population -- low-income mothers, infants and children -- would go without necessary health and nutrition services.

In addition to the 22 percent cutback in funding for the MCH block grant, the Administration has proposed a waiver of the current state matching requirement. This proposal directly contradicts a basic provision supported by CACH during the debate on the 1981 Budget Act and included in the public law. Specifically, this proposal would eliminate the statutory requirement that for each $4 in federal funds received by a state under the MCH block grant, the state must spend $3 of its own funds on MCH services.

Without this matching requirement, states no longer would be obligated to commit a definite amount of money to MCH projects. In effect, this proposal would afford states the opportunity to channel funds away from MCH projects, including those treatment programs funded in children's hospitals. Clearly, the shortfall in revenue for these programs could not be absorbed by our children's hospitals which currently are operating on restricted budgets.

Finally, the Administration is proposing to eliminate another basic provision fought for by children's hospitals and included in the 1981 Budget Act. The provision currently protects funds for MCH projects by stipulating that these funds cannot be used for purposes other than the provision or the purchase of maternal and child health and crippled children's services. Merging the mammoth WIC program with the MCH block grant would undercut the financial support for the more limited MCH projects. The various interest groups would have no option but to compete for the limited funds, albeit reduced funds, previously guaranteed only for MCH projects. Eliminating the statutory protection of these funds for maternal and child health and crippled children's services would mandate this design. CACH cannot support this further erosion of a fiscal commitment to MCH projects.

To support this nation's long-standing dedication to promote maternal and child health and crippled children's services, we urge this Congress to maintain funding at least at the FY 1982 authorization level of $373 million. We also recommend that you reject the proposed WIC/MCH merger and retain the present matching rate requirement to insure that states will commit these funds to maternal and child health and crippled children's services. Finally, we request that Congress, in recognition of the special vulnerability of children, insure that funding is authorized specifically for the provision or the purchase of maternal and child health and crippled children's services.

CONCLUSION

Because of the health care programs available through children's hospitals, hundreds of thousands of infants and children, who would have died a decade ago, now survive to live completely normal and productive lives. Yet, nearly 10 million children still have no known source of regular health care in this country. Recognizing this Administration's desire to address the adverse consequences of a high budget deficit, we nevertheless urge this Congress to realize that the Administration's proposed budget request would jeopardize health care services for thousands more children -- including children with special needs -- and high-risk pregnant mothers who have no means of paying private doctors, hospitals, or clinics.

Today, children's hospitals barely are withstanding severe cutbacks in their operating expenses due to reductions authorized by the 1981 Budget Act. These institutions simply cannot absorb further budget reductions, remain fiscally responsible, and continue to serve the health care needs of the community. We urge this Congress to ensure that the vital and unique health care programs available through children's hospitals are not endangered by additional budget cuts.

STATEMENT OF THE
AMERICAN DENTAL ASSOCIATION
ON
PRESIDENT REAGAN'S 1983 BUDGET PROPOSALS
BEFORE THE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
UNITED STATES SENATE
APRIL 14, 1982

The American Dental Association is pleased to have this opportunity to express its views on the impact of the President's budget proposals on the Medicaid program. Adult dental services currently are covered under Medicaid as an optional benefit. Dental benefits are mandated for Medicaid eligible children under the Early and Periodic Screening, Diagnosis and Treatment program. Because dental services are an integral part of overall health care, the Association believes that they should be a mandated service which is made available to all Medicaid beneficiaries. Given the current optional status of adult dental care under the law it is improper to exert further pressures on the states to reduce or perhaps totally eliminate this benefit.

According to preliminary responses to a survey of state Medicaid agencies which now is being conducted by the Association, 38 states currently provide some level of dental services for Medicaid eligible adults. This figure is brought into perspective, however, by the fact that in only 14 of these states is the coverage for adults equal to that available to children under EPSDT. Under the vast majority of these state plans coverage is limited to such services as emergency care and the provision of dentures. It also should be noted that dental care is largely excluded from coverage under Medicare.

Only last year 21 states provided dental care for adults which was comparable to that provided under the EPSDT program. The reduction in adult dental benefits which has occurred in the last year can be directly attributed to changes in the Medicaid law which reduced federal matching assistance to the states by 4% in fiscal year 1983. A 4.5% reduction already is called for during fiscal year 1984.

As shown by the above statistics, the ability of the states to provide dental care is continually being eroded. President Reagan has proposed a further reduction of 3% in the federal matching level to the states under the Medicaid program for all services which are provided to the medically needy and for optional services provided to the categorically needy. The result of this proposal if enacted will be either to require already financially overburdened states to incur even more expenditures for the payment of Medicaid services or, as is more likely, cause the states to reduce benefits, reduce eligibility or both. In particular a further 3% reduction in support for those aspects of the program which authorize coverage for dental care will only assure that dental services will become less and less available.

Very bluntly it must be pointed out that these reductions will almost guarantee that low income individuals in this country will no longer be able to receive even the limited dental benefits which currently have been made available.

The dental profession is generally in support of efforts to control federal spending as a means of reviving the nation's economy. The profession has absorbed its share and more of these cuts. Nevertheless, the Association must object at this time because of the very severe consequences which will be felt by low income individuals as a result of enactment of this proposal. Many programs including Medicaid already have faced significant reductions. There probably are areas where further cuts can be made. But in the interest of the health of more than 10 million low income adults these additional Medicaid cuts should not be enacted.

Thank you for your consideration of our views.

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